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How do people construct their identity when they are both a 'mental health professional' and a 'mental health service user''?

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Summary of the Portfolio

This portfolio explored how people construct their identity when they are both a 'mental health professional' (MHP) and a 'mental health service user' (MHSU).

Section A provides a review of the literature examining the evidence that there are MHPs who experience mental health problems and/or, are/have been MHSUs (MHPs-MHSUs). Literature suggests that the identity construction of MHPs and MHSUs is fundamentally different, therefore this review argues that the identity of MHPs-MHSUs needs to be explored, specifically from a social identity/discourse analysis (DA) perspective. The paper reviews the empirical literature that explores the identity of MHPs-MHSUs from a social identity/DA perspective, however due to the limited literature it includes literature exploring the experience of being a MHP-MHSU. The review highlights the need for further exploring the identity construction of MHPs-MHSUs.

Section B describes a study exploring how MHPs-MHSUs construct their identity using DA methodology. The paper gives a background and rationale for the study, and talks the reader through the methodology. Participants constructed their identity in a variety of ways, including as separate identities ('professional identity', 'patient/MHSU identity'), switching between the two in different contexts, therefore developing an 'un-integrated identity', as well as, developing an 'integrated identity' construction in some contexts. Implication for clinical practices and future research are discussed.

Section C provides a critical appraisal of section B. It focuses on the research skills and abilities developed, the researcher's reflections on the study and clinical implications. It suggests areas of further learning and future research ideas.

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Abstract

This paper explores how ‘mental health professionals’ (MHPs) who are also, or have been ‘mental health service users’ (MHSUs) construct their identities. Literature suggests that MHPs who are/have been MHSUs (MHPs-MHSUs) can be defined in different ways and this paper provides a review of the literature exploring 13 papers exploring ‘distress’ in MHPs, ten papers exploring the concept of the wounded healer and introduces the topic of MHSUs employed in mental health (MH) services, two papers were included but reviewed later in the paper. Literature suggests that within MH services the identity construction of MHPs and MHSUs is fundamentally different; therefore this review argues that the identity of MHPs-MHSUs needs to be explored, specifically from a social positioning and discursive perspective. Literature suggests that MHPs-MHSUs may be drawing on conflicting discursive resources making their identity difficult to reconcile, leading them to face dilemmas when constructing their identity. The paper reviews two empirical studies that explore the identity of MHPs-MHSUs from a social identity/discourse analysis (DA) perspective, however due to the limited literature in this area; it also includes seven empirical papers that explore the experience of being a MHP-MHSU and draws tentative conclusions from a DA perspective. The review highlights the need for further exploration of the identity construction of MHPs-MHSUs, and suggests adopting a DA approach.

Introduction

This paper begins by exploring the research into the occurrence of 'distress' in 'mental health professionals' (MHPs). The UK National Health Service (NHS) has begun employing people with lived experience of mental health (MH) problems, yet, as this paper will show, the social identities of MHPs and 'mental health service users' (MHSUs) are viewed as different. It will suggest that this may pose dilemmas for MHPs who are/have been MHSUs (MHPs-MHSUs). The paper reviews the evidence that there are MHPs-MHSUs, drawing from the literature on 'distressed professionals' (DPs), 'wounded healers' (WHs) and MHSUs employed in MH services.

The paper then looks at why it is important to explore identity. The review argues that a social-constructionist, discourse analysis (DA) perspective is useful to explore the linguistic resources available to MHPs-MHSUs and how these impact on their identity constructions. It then explores the literature on how MHPs-MHSUs construct their identity from a social perspective, and supplements this with empirical research on the experience of MHPs-MHSUs in their professional contexts, drawing tentative conclusions from this using a DA perspective. The review concludes by arguing that this area of research has both organisational and personal/professional implications and will consider potential areas for future research.

Methodology

Systematic literature reviews were conducted (appendix A).

Definitions

- MHPs - professionals working within a caring/therapeutic/treatment-provider role in MH services.

- MHSUs - Someone who is eligible to access services (Swift, 2002). For the purpose of this study services are those services specifically offered to people with mental health problems.

There are many different terms used to describe MHSUs including clients, consumers, ex-patients, experts by/through experience, patients, people with mental health problems/illness, people with experience of mental and emotional distress, psychiatric survivors, service users, sufferers, survivors and users (Mental Health Foundation, 2013).

- DPs - MHPs experiencing 'distress/impairment' caused by MH problems. The definition of 'distress/impairment' is disputed in the literature (Smith & Moss, 2009). O'Connor (2001) suggested that 'distress' does not necessarily result in 'impairment'.

- WHs - a person whose experience of illness/trauma has left lasting effects on them which are used with future clients (Jackson, 2001).

- Professional Identity - for the purpose of this paper professional identity refers to how MHPs perceive who they are in their professional context, that is ones' professional self-concept/role/image (Ibarra, 1999), based on their beliefs, motives, experiences and interactions with others.

What evidence is there for the occurrence of MHPs-MHSUs?

Evidence suggests that one in six adults has a MH problem (Department of Health; DOH, 1999a) and one in four experiences MH problems during their life-time (DOH, 2001; Future Vision Coalition, 2009). It is therefore likely that there are MHPs-MHSUs working within MH services. The literature appears to categories and define MHPs-MHSUs into three areas; 'distressed professionals', 'wounded healers' and MHSU employed in MH services, therefore this paper will begin by exploring the empirical literature in these areas in order to provide evidence that there are MHPs-MHSUs.

'Distressed Professionals'

There is a vast amount of literature indicating high levels of DPs (Sherman, 1996; Swearingen, 1990; Wilson et al., 2009). Literature suggests that psychologists are no less

than the average person to experience distress (Barnett, Baker, Elman & Schoener, 2007) and between five and 15% are impaired (Laliotis & Grayson, 1985). Vyas and Luk (2010) suggested that rates of depression in social workers (SWs) are increasingly being reported.

The literature search identified 13 empirical studies on DPs. Gilroy, Carroll and Murra (2002) found 62% of counselling psychologists self-identified as depressed. Floyd, Myszka and Orr (1998) found that 10% of psychologists estimated that their colleagues were DPs (15% historically). Wood, Klein, Cross, Lammers and Elliot (1985) found that 60% of psychologists reported a colleague experiencing depression and 32.3% had themselves experienced depression. Guy, Poelstra and Stark (1989) found 3.1% of psychologists were DPs. The American Psychological Association (APA) found that 40-60% reported a little disruption in professional functioning due to anxiety/depression (APA, 2002).

Deutsch (1985) found that 57% of psychotherapists reported that they had been depressed; other diagnoses included psychosis, anxiety and psychosomatic ailments. Pope and Tabachnick (1994) found that 61% of therapists had experienced clinical depression, with one in five participants' depression causing major 'distress'. Kluft (1990), as part of a file trawl, found 20 psychotherapists with a diagnosis of multiple personality disorder or other dissociative disorders and co-occurring conditions (personality, anxiety, post-traumatic stress, depression, dysthymia and eating disorders).

Willi (1983) found that psychiatrists were prone to psychosomatic and mental disorders. Deary, Augis and Sadler (1996) compared stress-related variables of consultant psychiatrists and physicians/surgeons; psychiatrists reported higher levels of MH problems, including severe depression. Manthorpe, Stanley and Cann (2002a; 2002b) found that 80% of SWs had experienced depression. Siebert (2004) found that 14% of SWs reported current depression and 46% past depression.

This literature suggests that there are MHPs with MH problems, who could be defined as DPs. However these studies have methodological limitations. Most were survey designs, which could have been affected by self-report bias, i.e. social desirability, recall inconsistencies and reports cannot be verified. The sample sizes were small, specific, lacked diversity and some were self-selecting, leading to problems with generalizability. Results were limited through the use of closed questions. There was no consensus on how 'distress' should be defined or explored between the studies, making it difficult to draw clear conclusions.

'Wounded Healers'

Research suggests that MHPs experience 'distress' because they are self-selected from vulnerable populations. The concept of the WH developed from ancient Greek mythological figures (Bradley, 2009; Conti-O'Hare, 2001; Dunning, 2006; Kirmayer, 2003). O'Connor (2001) suggested that those with traumatic childhoods or 'parentification' in their family of origin choose a career in the helping professions in order to repair/address/master earlier dysfunction or continue the caretaking role, predisposing them to MH problems (Farber, Manevich, Metzger & Saypol, 2005; Racusin, Abarmowitz & Winter, 1981; Trusty, Ng & Watts, 2005).

The literature search identified 10 empirical studies on WHs. Farber et al. (2005) found that therapists experience more psychological pain in childhood and their heightened awareness of 'distress' in themselves/others influences their career choice. Elliott and Guy (1993) found that psychologists/psychotherapists/therapists were more likely to report childhood trauma compared to other professionals. Racusin et al. (1981) reported that 50% of psychotherapists recalled child abuse, alcoholism, 'parentification' and/or a family member with psychological/physical difficulties in their family of origin. Pope and Feldman-Summers (1992) found that 69.93% female and 32.85% male clinical/counselling psychologists cited a

history of physical/sexual abuse. Orlinsky and Ronnestad (2005) found that 48% of psychotherapists reported that their career choice had been influenced by the motivation to explore/resolve personal problems. Barnett (2007) explored nine psychotherapists' motivations for career choice and found major themes of early loss, narcissistic needs and the concept of the WH. Wolgien and Coady (1997) reported that therapists felt that their difficult personal experiences had influenced the development of their helping ability.

Ford (1963) reported that 24 out of 25 psychiatrists chose their career due to needing to explore personal conflicts. Frank and Paris (1987) found in a survey of 66 psychiatrists and 246 other professionals, psychiatrists experienced more disappointment in their parents. Siebert (2004) reported that many depressed SWs had experienced physical/emotional abuse and a troubled parent during their childhood. Pooler, Siebert, Faul and Huber (2008) found that 'distressed' SWs reported experiencing a troubled parent/primary caregiver (28%), abuse (38%), death of a sibling/parent (14%), an ill parent (10%) and divorce (14%), during their childhood.

These empirical studies support the theoretical concept of the WH and provide evidence that MHPs may be self-selected from vulnerable populations, predisposing them to 'distress'. However, according to Jackson (2001), it is unlikely that all 'healers' have/need to be WHs, and that everyone has 'wounds' which can be drawn upon (Zerubavel & Wright, 2012). There are methodological limitations of these studies including self-report bias, limited samples and no comparison studies as mentioned above, leading to problems with generalizability and drawing clear conclusions regarding elevated rates of vulnerability in MHPs. Participants may have experienced memory difficulties leading to underreporting of traumatic experiences.

MHSUs employed in MH services

Literature highlights that MHSUs are increasingly employed in MH services (Barrett, Pratt, Basto & Gill, 2000; Fisher, 1994b; Perkins, Rinaldi & Hardisty, 2010). There was no empirical literature that explored MHSUs employed in MH services, from a social identity/DA perspective, possibly due to this being a relatively new concept/area of research. However two studies were identified which explored the experience of MHSUs employed in MH services, which will be reviewed later (Berry, Hayward & Chandler, 2011; Van Erp, Hendriksen-Favier & Boer, 2010).

So far this paper has shown that there are MHPs-MHSUs. It is important to explore how MHPs-MHSUs construct their identity because the literature suggests that MHPs and MHSUs have contradictory roles, positions, expectations and identities (Davis, 2003). Before exploring this further the author will introduce theories of how identity is conceptualised.

What issues might arise for the identity of MHPs-MHSUs?

A Social Constructionist Perspective

Identity can be conceptualised from a modernist perspective which has an empiricist/positivist epistemology and assumes that researchers are able to discover truth (Hoffman, Hoffman, Robinson & Lawrence, 2005). It believes that there is one true stable self/identity that is unchangeable (Marshall & Wetherell, 1989). Modernist theories include; Individual Maturation Theory (Erickson, 1997), Symbolic Interaction (Mead, 1934), Trait Theory (Allport & Odbert, 1936), Role Identity Theory (Côté & Levine, 2002; Marcia, 1996) and Social Identity Theory (Tajfel & Turner, 1979). Modernist theories have been criticised for reducing the complexity of identity formation and ignoring the various contradictions/components that exist within their construction (Deaux & Stewart, 2001; Hoffman et al., 2005).

Post-modernist theories hold a social-constructionist epistemology that is anti-realist/essentialist/totalistic and is based on pluralism and holism (Anderson, 1995; Hoffman, Stewart, Warren & Meek, 2006). It suggests that people construct their own reality based on shared belief/assumptions about the world; imposing these social constructions onto the background of logical/physical reality, when negotiating social life (Harré & Langenhove, 1999). Discourse analysis (DA), a social constructionist methodology, sees 'talk' ('discourse' - social episodes of speech occurring in everyday life that make up the basic elements of the stories that we construct about our social world, Harré & Langenhove, 1999) as social action, in that it is functional, constructive, productive, performative and dependent on context (Potter & Wetherell, 1987; Willig, 2008). Language is viewed as an important aspect of identity, which is described as multifaceted, fluid, dynamic and conflicting, continuously created, renegotiated and reinvented within social interactions (Davies & Harré, 1990; De Fina, Schiffrin & Bamberg, 2006). There are multiple selves, embedded in social contexts/relationships (Davies & Harré, 1990; Gergen, 1991), which are culturally relative, historically contingent, ideologically informed and dependent on experience of social practices, which give structure/meaning (Henderson & Alkinson, 2003; Holmes, 2006; Potter & Wetherell, 1987).

Positioning theory comes from a critical realist perspective (Harré & Langenhove, 1999). It examines the construction of identity, through which speakers adopt/resist/offer subject positions, made available by discursive resources (Benwell & Stokoe, 2006). Identity is derived from logical pairing, people position themselves/others in a way that leads to descriptions of themselves 'as something' and the others as 'not something'; where typically the other is viewed as devalued/incompetent, e.g. doctor-patient (Davis, 2003; Harré & Langenhove, 1999). Harré and Langenhove (1999) suggested that certain expectations/rights; ways of acting/behaving/being, are created in different positions and freedom to position

oneself depends on access to power and dominant discourses (Parker, 1992; Sampson, 1993). According to Billig et al. (1988), the discursive resources people draw on are inherently dilemmatic, containing contradictory ideas, which may leave people holding competing discourses and positions, with different power implications (Billig, 1991; Davis, 2003).

Benwell and Stokoe (2006) suggested that discourses regulate power through socially constructed identities. Those maintained by social arrangements/practices survive and become dominant, because they serve important social functions and become social norms/'truths' (Foucault, 1972; 2001; Potter & Wetherell, 1987). Positions can become fixed (Gilbert, 1994) and powerful institutions remain static because the limited discourses available to them maintain power relations (Foucault, 2001; 2003; Waal, Malik & Bhugra, 2010; West & Zimmerman, 1987). Social power plays a role in the way speakers position themselves/others, and are positioned (Potter & Wetherell, 1987), as demonstrated by Harper's DA research. Harper (1995) suggested that MHSUs are seen as 'mad', a position/identity afforded to them by disempowering discourses. Harper (1998) explored MHP's accounts of why medication was not working and found that MHPs constructed different types of identities for their patients, e.g. 'resistant', 'non-responder', locating the problem in the patient rather than in the medication. Stevens and Harper (2007) interviewed MHPs about their use of electroconvulsive therapy. They suggested that MHPs drew on a repertoire which constructed MHSUs as 'severely ill', supporting their treatment choice. Harper (1994) explored how MHPs talked about paranoia and suggested that MHPs positioned themselves/were positioned by a number of discourses that served to maintain professional legitimacy.

However there are limitations of this research. Authors did not independently verify their analysis, conduct respondent validation or triangulate their research. Garety (1994) and Walkup (1994) commented on Harper's (1994) paper, suggesting that he used overly

broad/vague discursive constructions and concluded what he had always intended. However, DA allows researchers to question 'taken-for-granted' understandings, takes a non-traditional research strategy and values human and theoretical diversity (Harper, 1995; Stevens & Harper, 2007). According to Harper (1994), this method of analysis is useful when exploring MH; therefore DA provides a useful basis for exploring the possible dilemmas MHPs-MHSUs may experience.

It could be assumed that the identities of MHPs-MHSUs are constructed through language and the discourses drawn upon in social interactions (Harré & Langenhove, 1999; Willig, 2008). MHPs-MHSUs may pull on their different identities, to varying degrees, depending on context (Potter & Wetherell, 1987), sometimes as an active/less active process (Benwell & Stokoe, 2006; Harré & Langenhove, 1999). However, how do they construct their identities when MHPs and MHSUs are viewed differently within society and what dilemmas do they face when negotiating their identities in professionals settings? The paper will now review the theoretical/empirical literature that explores this question.

Potential dilemmas faced by MHPs-MHSUs

Walsh, Stevenson, Cutcliffe and Zinck (2008) suggested that the dominant model of understanding mental illness (MI) is a psychiatric/medical model which focuses on clinical recovery (Slade, 2009). Within this model research suggests that certain MHP and 'patient' identities are constructed. Frese and Davis (1997) suggested that for 'patients' a life with relationships, education, occupation and independence is no longer achievable because they are viewed as unable to recover. 'Patients' are viewed as needing 'experts' to label/treat them (Bassman, 1997), therefore their role/status becomes that of a powerless victim and a passive recipient (Adame & Kundon, 2007; Frese & Davis, 1997; Schiff, 2004). They experience stigma/prejudice/discrimination (Thornicroft, 2012) from the public (Corrigan, Markowitz, Rowan & Kubiak, 2003; Wahl, 1995) and from MHPs (Basset, Campbell & Anderson, 2006;

Hossack & Wall, 2005). They are socially devalued/dehumanised/excluded (Stanley, Ridley, Harris & Manthorpe, 2011) and seen as 'mad people' (May, 2001), who have nothing useful to say (Campbell, 1996; Rose, 2008; Scheff, 1966). According to Slade (2009), they develop a 'mentally ill patient/spoiled' social identity (Goffman, 1963), which is dominated by the MH problem. Within the psychiatric/medical model, according to Schiff (2004), MHP's identities are constructed very differently (Slade, 2009). They are viewed as 'experts', powerful, trustworthy, autonomous, hold authority and are therefore listened to (Davis, 2003; Shepherd, Boardman & Slade, 2008; Tse, Cheung, Kan, Ng & Yau, 2012).

It could be assumed that one of the dilemmas that may arise for MHPs-MHSUs is how they construct their identity when the identities of MHPs and MHSUs are very different and historically people with a MI were viewed as separate from the rest of the population, enforcing the 'them and us' divide (Schiff, 2004). ResearchNet (2011) suggested that MHPs and MHSUs are 'fundamentally different kinds of people' (p. 69). According to Shepherd, Boardman and Burns (2009; 2010), MHPs are reluctant to move away from their 'expert' role and adopt the 'patient role'. Rucinski and Cybulska (1985) suggested that being a MHP-MHSU is a radical role reversal, which undermines the MHP's identity (Kilitzman, 2008). According to Rose (2008), this 'double identity' is not easy to manage because it is paradoxical, combining 'madness' with 'reason'.

Another dilemma may be how MHPs-MHSUs deal with the idea that MHPs are somehow beyond/detached from 'distress' (McCourt, 1999). May (2001) suggested that 'mad/bad/sad' experiences cannot be spoken by MHPs because they are seen as 'sanity consultants' (Norman & Rosvall, 1994). According to Good, Khairallah and Mintz (2009), MHPs are lulled into dualistic perspectives of wellness and impairment; they are the healthy ones whose identity is socially, politically and personally different from those 'troubled' and is framed by giving rather than receiving help (Siebert & Siebert, 2007).

Another dilemma may be how MHPs-MHSUs talk about their experiences when this topic is described as a taboo (Schulze, 2007). Shepherd et al, (2009; 2010) highlighted that there is limited awareness/acknowledgement of current staff's own experience of MI. Research suggests that a culture has developed where MHPs with MH problems are wary of, and rarely disclose their difficulties (Kottsieper, 2009; Fisher, 1994b). Research suggests that MHPs-MHSUs do not disclose due to fear of experiencing stigma, prejudice, discrimination, judgement and hostility (May, 2001; Snow, 2002; Walsh, Nichols & Cormack, 1999), leading to them being ostracised and embarrassed (Barnett & Hillard, 2001) and possibly losing one's status as a MHP (Swearingen, 1990, Fitness to Practice; McCourt, 1999). Research suggested that MHPs do not disclosure due to fear of others questioning their competence, being unclear regarding the impact on their clinical work, fear of relapse (Zerubavel & Wright, 2012), fear of being viewed as a client (Cain, 2000), fear of feeling powerless, incompetent and shameful (Swearingen, 1990), therefore gaining a devalued identity (Fisher, 1994b; Stanley, Ridley, Harris & Manthorpe, 2011; Wood et al., 1985).

Research and the media shows that people are becoming more vocal about being affected by MI (Slade, 2009). The service user movement challenged the psychiatric/medical model and spoke out in order to reject their role/status of powerless, stigmatised victims (Frese & Davis, 1997; Rose, 2008). They aimed to reclaim their rights, become agents of change and represent themselves as rational, hard-headed negotiators (Adame & Kundon, 2007; 2008; Bassman, 1997). From this the idea of the personal recovery model developed (Schiff, 2004; Kottsieper, 2009). The most cited definition of recovery is,

> A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles as a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning

> and purpose in one's life as one grows beyond the catastrophic effects of MI (Anthony, 1993, p.17).

The NHS has adopted a framework for organisational change based on recovery oriented care (ROC; Andersean, Oades & Caputi, 2003). There is emerging policy consensus that the primary goal of MH services is to promote recovery (DOH, 1998; 1999b; 2001; 2004; 2006; 2007a; 2007b; 2009; NICE, 2011; The Future Vision Coalition, 2009), with documents calling for a culture where lived experience of MH problems is viewed positively in MHPs who have it (Shepherd et al., 2009; 2010). Professional groups including psychiatry, nursing, occupational therapy and psychology have adopted ROC (British Psychological Society, 2000; College of Occupational Therapists, 2006; Royal College of Psychiatry, 2007).

Some researchers have suggested that ROC is shifting the view of MI from the highly dominated medical model of disease, diagnosis, pathology, illness, symptoms and social exclusion, to a model of health, recovery, strength, meaning, hope, healing, wellness, value and inclusion (Jhangiani & Vadeboncoeur, 2010; May, 2001; Shepherd et al., 2008; Jacobson & Greenley, 2001). Slade (2009) suggested that ROC challenges the 'them and us' divide, reducing the power imbalance between MHPs and MHSUs, creating a change of culture within the MH system (DOH, 1998; 2004; Future Vision Coalition, 2009; Link & Phelan, 2001; NICE, 2011). According to Shepherd et al. (2008), ROC allows MHSUs to develop a positive/preferred identity separate from MI (Oades, Crowe & Nguyen, 2009).

Some MHPs have begun to disclose their MH problems and draw on their experiences verbally and in professional journals/autobiographies (Ahmed, 2007; Bassman, 2001a; 2001b; Baxter, Vogel-Scibilia & Johnson, 1997; see also appendix F). According to Jhangiani and Vadeboncoeur (2010), MHPs may be able to disclose because ROC allows individuals to develop a more positive identity. Adame (2011) suggested that MHPs-MHSUs

could be said to be challenging the dominant 'psychiatric/medical discourse' by viewing MI as normal human experience and therefore as more positive. According to Bracken and Thomas (2001), the recovery model offers an alternative, empowering 'recovery discourse', which values personal narratives/experience. Speed (2007) suggested that a 'consumer discourse' is emerging, where consumers are viewed as rational, active, informed and empowered, developing a discourse of self-determination and satisfaction of needs (Long, 1999). However, Walsh et al. (2008) suggested that ROC may collapse amid the traditional 'psychiatric discourses' due to their taken-for-granted power, knowledge, resources and authority (Kemshall & Littlechild, 2000). Warne and Stark (2004) suggested that even though MHSUs involvement is increasing, services are dominated by a discourse of treatment, control, compliance and professional expertise. Bertram (2002) suggested that for the culture to change there needs to be a change in the balance of power, as current structures and discourse gain/maintain/emphasise the imbalances of power (Hui & Stickley, 2007).

This paper will now review the empirical literature that explores the identity of MHPs-MHSUs, from a social/DA perspective. The research has gone some way to explore how MHPs-MHSUs construct their identity and the dilemmas they face; however it is limited.

What evidence is there about how MHPs-MHSUs construct their identity?

There were nine empirical studies relevant to this question. Adame (2011) explored 11 psychiatric 'survivor' psychologist's relationship between their identities and the implications of identifying with different discourses. Participants spoke about their two identities complementing one another and how they were 'grounded' by their 'survivor identities', highlighting the interdependent/interrelated nature of the identities. Participants spoke about the risks/benefits of self-disclosure and questioned who they were because they did not conform to what others expected of them. Most did not disclose when in the 'therapist

role' due to experiencing stigma, isolation and questions regarding their competence, but acknowledged their experience could be a source of hope. Participants were concerned about disclosing their 'professional identity' to survivors due to being seen as not a 'real' survivor and untrustworthy. Participants spoke about how their 'survivor identity' influenced their work including renewing their appreciation for the healing qualities of a genuine connection. Others spoke about being aware of over-identification, but using it productively. Participants spoke about 'them and us' dichotomies lessening when professionals write about their experiences of MH problems and by acknowledging that psychological suffering is part of human experience, but increasing due to hierarchical power struggles and training separating those with/without MH problems. Adame (2011) suggested that it appeared easy for participants to get drawn into the rigid discourses from either side; however this may allow opportunities for developing alternative/new alliances between people who would like to see change.

Joyce, Hazelton and McMillan (2007) explored the experiences of 29 nurses with MH problems. Participants spoke about experiencing a shift in their sense of self from nurse to patient, leading them to become aware that anyone can develop a MI. Participants spoke about their colleagues trying to reform their 'patient behaviour' through ill-treatment and victimisation based on their negative beliefs about MI. Others spoke about feeling positively supported and nurtured by their colleagues. Participants spoke about colleagues using their power to impose the 'patient role' onto them, others spoke about being assertive, knowing their rights and challenging the beliefs that someone with a MI is incapable. Participants spoke about them being viewed as fragile and a threat to themselves/others. Most participants spoke about the experience of being a MHP-MHSU negatively, not conforming to the rule of normality, therefore experiencing discrimination. These two studies suggested that dilemmas exist when MHPs-MHSUs construct their identity, including the mixed/complex experience

felt by MHPs-MHSUs, including a negative MHSU identity which is hard to overcome (Adame, 2011; Joyce et al., 2007).

The following seven studies explore the experiences of MHPs-MHSUs and provide further evidence for the dilemmas they experience when constructing their identities. The studies do not explore this from a social/DA perspective; however it seemed important to include them due to the limited literature specifically looking at the identity of MHPs-MHSUs from a social/DA perspective. It has been argued throughout this paper that a social/DA perspective is helpful when looking at this topic, therefore the author will summarise the findings of the studies individually and then conclude what may be drawn from them using a DA perspective.

Lindow and Rooke-Matthews (1998) explored the experiences of 39 MHPs-MHSUs. Participants spoke about the dilemma of disclosure, being uncertain as to whether it would be viewed positively/negatively. Some disclosed and experienced prejudice/discrimination, were treated as vulnerable, not promoted, disbelieved, accused of crossing boundaries/over-identification, experienced increased surveillance and felt devalued. Participants spoke about the positive ways being a MHP-MHSU added value to their work including additional understanding of patients' lives/experiences, a positive attitude towards the work and a helpful perspective for colleagues.

Cain (2000) explored the countertransference issues faced by ten MHPs-MHSUs in their work as psychotherapists. Participants spoke about the positive impact of countertransference on themselves and clients, including learning about themselves, using self-disclosure, their histories helping clients, inspiring and informing their work, making them have less stigmatising attitudes towards clients and facilitating trust and hope. Participants spoke about the negative impact of countertransference on themselves including feeling discomfort, anxiety, isolation, vulnerability, frustration and being reminded of

difficult times, and clients being affected by over-identification and fluctuations in the therapist's well-being. Participants spoke about stigma being the main reason why they were hesitant to disclose.

Gilroy, Carroll and Murra (2001) explored psychotherapists' depressive symptoms and its impact on their clinical work and colleague relationships. Participants spoke about the positive effects their depression had on clinical work including having increased empathy, sensitivity, compassion, insight, knowledge, patience and understanding. They spoke about the negative effects including reduced energy, confidence, concentration, enthusiasm, memory and ability to be emotionally present. Some participants spoke about their depression improving and strengthening relationships with colleagues, receiving support from colleagues and the development of mutual sharing. Others spoke about their negative experiences with colleagues including feeling withdrawn, isolated, judged, ostracised and less respected. Some participants felt their depression had no effect on their clinical work or colleague relationships. Some did not disclose due to fears of colleagues losing respect for them or questioning their competence.

Stanley, Manthorpe and White (2007) interviewed 50 SWs about the causes, consequences and management of their depression. Participants spoke about the dilemma of disclosure. Some fully disclosed, whereas others hid their depression. Participants feared disclosure due to feeling that they were letting their colleagues down, fear of being seen as not coping, stigma and issues regarding confidentiality. Some participants spoke about experiencing supportive and sympathetic reactions to disclosure including receiving adjustments to working hours, load and environment. Others spoke about experiencing negative, bullying and intolerant reactions, with no adjustments.

Van Erp et al. (2010) interviewed MHSUs about their experiences of being employed in MH services. They defined their MHSUs as consumer-providers, highlighting that they

had been MH consumers/service users who were now working in MH services in a professional role as providers. Participants spoke about the challenges of being a consumer-provider including disagreeing with colleagues but finding it difficult to raise these matters, feeling insecure about what to tell colleagues about their background due to fear of being treated differently, finding it difficult to maintain appropriate distance from clients due to their multiple relationship and fear of losing their unique perspective in favour of adopting professional beliefs/roles.

Berry et al. (2011) explored the experiences of two peer support workers (PSWs) who highlighted a discrepancy between the 'PSW identity' and reality of the role, making it difficult to sustain peer values. PSWs spoke about awareness of ambivalent attitudes towards them, including concern about their stability, confidentiality and fear of them taking over the workforce. PSWs spoke about there needing to be a widespread culture change as there is still resistance to MH disclosure in staff not working within the specific PSW role, due to anxiety regarding their professional status.

Charlemange-Odle, Harmon and Maltby (2012) explored the experience of 11 psychologists in 'distress'. Participants spoke about the impact of 'distress' on client work including being more emotional/empathic, as well as feeling useless, helpless and different. Participants spoke about how professional knowledge can be both beneficial and lead to self-criticism. Some participants spoke about the positive and reciprocated experiences of sharing their 'distress' with colleagues. Others spoke about needing to maintain pretence of the psychologists' role, fearful of being viewed as weak, less serious, inferior and not functioning well. Participants were concerned about the influence it may have on career progression as 'distress' within the profession is a taboo. Participants spoke about their 'distress' leading to a deeper understanding of clients, having a unique insight and leading to a shift in how they approached clients.

The above seven studies provide empirical evidence for the dilemmas faced by MHPs-MHSUs when constructing their identity. From a DA perspective, it may be suggested that the main identity dilemma being alluded to is how MHPs-MHSUs construct their identities, when the two identities they are drawing on are so fundamentally different (ResearchNet, 2010). To use the participants' words, judged, stigmatised, weak, vulnerable, inferior and devalued (MHSUs) versus competent, functioning well, respected and serious (MHPs). From a DA perspective it may be assumed that when constructing a 'MHP identity' one may be drawing on powerful, dominant discourses which position one as superior, as compared to constructing a 'MHSU identity' where one may be drawing on less powerful, minority discourses, imposed by those in positions of power, therefore developing a devalued identity (Parker, 1992; Sampson, 1993). When someone is a MHP-MHSU, there is a tension because they are drawing on both of these contradicting discourses (Billig et al., 1988; Billig 1991); therefore their identity is difficult to reconcile, leading to the mixture of experiences described above with positive and negative connotations, causing dilemmas to arise. It might be argued that participants tried to solve these dilemmas by actively negotiating their social identity, adapting their identities dependent on context (Davis, 2003; Gergen, 1991), for example choosing to say/do something i.e. disclose to different people at different times (Stanley et al., 2007). However, on other occasions it may have been a less active process, where participants find themselves acting into different identities because they have been imposed upon them i.e. having the 'patient role' imposed when in the professional role (Lindow & Rooke-Matthews, 1998). However research is needed to explore these ideas further.

The above studies have many methodological limitations. Most of the studies had a small number of specific participants, potentially due to low response rates, leading to problems with bias and generalizability. In most studies participants volunteered to take part,

again leading to problems with transferability and this may also mean that some strong individuals with specific views may have been heard more widely. Some authors acknowledged that these experiences were shared at a particular point in time, within a given context, which were then individually analysed by researchers and may therefore not represent participants' original stories, leaving unanswered questions regarding the quality of the analysis and may lead to problems with transferability. Many studies were interview based and therefore could have been affected by self-report bias. These limitations lead to questions regarding the transferability of results and therefore mean that the results need to be interpreted with caution.

However in support these studies provide some useful empirical evidence for the dilemmas and issues alluded to through the literature in this paper. The studies also had relatively good sample sizes when critiquing from a qualitative perspective. The topic area also lends itself more easily to qualitative methods as this allows for this richness of data to be represented. Some authors documented that even though their samples were specific they felt that they had a representative sample of the population they were studying. Some authors also provided information about how they assured the quality of their studies and provided information about how they collected their data (interview schedules and questionnaires) allowing for easy replication. Many dilemmas were common across studies, giving more weight to the findings collectively. Therefore these studies begin to provide some information on how MHPs-MHSUs construct their identity, however this area of research is very limited and much further exploration is needed.

Future Research Recommendations and Clinical Implications

This paper highlights that there currently lacks an in-depth consideration of the identity construction of MHPs-MHSUs. It seems timely to investigate how MHPs-MHSUs construct their identity as a growing number are disclosing, but the theoretical, empirical and

clinical knowledge of identity construction is limited, with a lack of awareness of powerful relationships and influence of social structures.

The dynamic nature of the dichotomies MHPs-MHSUs hold and the wielding of social power in relation to them might be more clearly captured using DA. It could help describe the range of identity constructions and discursive resources available to MHPs-MHSUs; how they are represented in different contexts, how they position the speaker and their social consequences. It may address the gap in current literature, allow new discourses to be systematically documented and heard more widely, and create a greater awareness/understanding of the dilemmas MHPs-MHSUs faced in their professional contexts.

It would be beneficial to replicate these current empirical studies taking into account the methodological limitations in order to add weight and further explore these topics. Exploring the impact of implementing ROC from a DA perspective, investigating whether there have been changes in the discursive resources available surrounding MI would be beneficial. There is a need to further explore how MHPs-MHSUs construct their identity using DA and how they negotiate dilemmas that arise. For example, exploring 'talk' and 'text' in various contexts, i.e. client or colleague interactions, of various professional disciplines, i.e. those more or less informed by the medical model, of professionals with different MH problems, i.e. more or less severe, and of those who have 'come out' versus those who are hidden.

This information may help us become more aware of how to challenge the idea that MHPs are 'superhuman' (Deutsch, 1985) and develop a professional ethos that places more value/focus on self-care of all members. It may provide useful information about how different services foster different identity constructions and the societal influences on people's wellbeing. It may increase people's awareness of how MHSUs are viewed and may

therefore erode some of the barriers between MHPs and MHSUs, including stigma/prejudice/discrimination and 'them and us' dichotomies, rendering services more effective and user-friendly (Stanley et al. 2007) .

Conclusion

This paper concerned itself with exploring the theoretical and empirical literature examining how MHPs-MHSUs construct their identities. The paper began by exploring whether there are MHPs-MHSUs and reviewed the literature looking at DPs, WHs and MHSUs employed in MH services. It then went on to investigate the concept of identity and suggested that looking at identity from a post-modernist social identity/DA perspective was beneficial when exploring MHPs-MHSUs identity as research suggests that they have two identities which have contradictory roles, positions, expectations and social power (Davis, 2003). The paper then reviewed the empirical literature looking at MHPs-MHSUs from a social/DA perspective. This literature was limited; therefore empirical literature examining the experience of MHPs-MHSUs was also reviewed and tentative conclusions were drawn from a DA perspective. This paper concluded with ideas for further research and implications for clinical practice.

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How do ‘mental health professionals’ who are also, or have been ‘mental health service users’ construct their identities; A Discourse Analysis

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Abstract

Literature suggests that there are a growing number of ‘mental health professionals’ speaking out about their own experiences of using mental health services. Research suggests that these professionals face dilemmas when constructing their identity because they are drawing on two identities that are viewed as fundamentally different, i.e. ‘mental health professionals’ as powerful and ‘mental health service users’ as powerless.

This study aimed to explore how ‘mental health professionals’ who are/have been ‘mental health service users’ construct their identity using a social constructionist epistemology, which views identity as fluid and continuously renegotiated in social contexts (Davies & Harré, 1990; Potter & Wetherell, 1987).

Ten participants who self-identified as ‘mental health professionals’ who are/have been ‘mental health service users’ volunteered to take part. Interviews were transcribed and analysed using discourse analysis. Participants constructed their identity in a variety of ways, including as separate identities, i.e. a ‘professional identity’ and a ‘patient/mental health service user identity’ constructions, switching between the two in different contexts, therefore developing an ‘un-integrated identity’. Participants also developed an ‘integrated identity’ construction in some professional contexts. These results are discussed and implications for clinical practice and future research are explored.

Introduction

Literature suggests that there are a growing number of 'mental health professionals' (MHPs), who are/have been 'mental health service users' (MHSUs), speaking out about their mental health (MH) service use. They are doing this verbally and/or through professional journals and autobiographies (Ahmed, 2007; Bassman, 2001a; 2001b; Baxter, Vogel-Scibilia & Johnson, 1997; see also appendix F). The literature categorises MHPs who are/have been MHSUs (MHPs-MHSUs) as 'distressed professionals'; MHPs experiencing 'distress/impairment' caused by a MH problem (Sherman, 1996), 'wounded healers'; someone who has experienced illness/trauma which has left lasting effects on them used with future clients (Jackson, 2001) and MHSUs employed in MH services (Perkins, Rinaldi & Hardisty, 2010).

Recent policy documents, embraced by MH services, focus on recovery oriented care (ROC; Andersean, Oades & Caputi, 2003; DOH, 2001), and have called for a culture where lived experience of MH problems is viewed positively in MHPs who have it (Shepherd, Boardman & Burns, 2009; 2010). According to Walsh, Stevenson, Cutcliffe and Zinck (2008), ROC has shifted the view of mental illness (MI), from a dominant medical/psychiatric model, which focuses on biology, disease, diagnosis, pathology, illness and symptoms (Slade, 2009), to a model which focuses on health, strength, meaning, hope, healing, wellness, value and inclusion (Jacobson & Greenley, 2001; May, 2001; Shepherd, Boardman & Slade, 2008). Frese and Davis (1997) suggested that within the medical/psychiatric model, MHSUs are viewed as being unable to recover and take control of their lives; with their role/status becoming that of a powerless victim and a passive recipient, developing a dominant identity of a 'mentally ill' patient (Adame & Kundon, 2007; 2008; Bassman, 1997; Frese & Davis, 1997; Slade, 2009). According to Schiff (2004), within the medical/psychiatric model, MHPs identities are constructed as very different. They are

viewed as ‘experts’, powerful, trustworthy, autonomous, hold authority and are listened to (Davis, 2003; DOH, 2001; Slade, 2009; Tse, Cheung, Kan, Ng & Yau, 2012).

With MH services now embracing ROC, Shepherd et al. (2008) have suggested that this may allow MHSUs to develop a positive identity separate from MI, moving towards a preferred identity and meaning of life (Oades, Crowe & Nguyen, 2009). According to Jhangiani and Vadeboncoeur (2010), MHPs-MHSUs have been able to speak out about their MH service use, because ROC changes the identity, status and meaning of being a MHSU from a negative to a more positive experience. Adame (2011) suggested that MHPs-MHSUs could be said to be challenging the dominant ‘psychiatric/medical discourse’ by normalising MI. However there is limited research exploring the impact of MH services embracing ROC, with some researchers suggesting that the medical/psychiatric model still dominates (Bertram, 2002; Hui & Stickley, 2007; Warne & Stark, 2004).

Therefore MHPs-MHSUs may face dilemmas when constructing their identities because within the medical/psychiatric model MHP’s and MHSU’s identities are viewed as fundamentally different (ResearchNet, 2011). According to McCourt (1999), MHPs are viewed as somehow beyond distress and therefore being a MHP-MHSU involves a radical role reversal (Rucinski & Cybulska, 1985). Shepherd et al. (2009; 2010) suggested that MHPs are not willing to move away from their ‘expert’ role and hold negative attitudes towards MHSUs and MHPs-MHSUs (Barrett, Pratt, Basto & Gill, 2000; Basset, Campbell & Anderson, 2006; Fisher, 1994b; Hossack & Wall, 2005). Another dilemma may be how MHPs-MHSUs ‘talk’ about their experiences when this topic is a taboo within the profession (Schulze, 2007).

Post-modernist research focuses on language and sees ‘talk’ as an important aspect of identity construction (De Fina, Schiffrin & Bamberg, 2006; Davies & Harré Harré, 1990). Identity is seen as fluid and continuously renegotiated in social contexts (Davies & Harré,

1990; Potter & Wetherell, 1987). Benwell and Stokoe (2006) suggested that discourses; social episodes of speech occurring in everyday life, that make up the basic elements of the stories that we construct about our social world (Harré & Langenhove, 1999), regulate power though socially constructed identities. The post-modernist methodology of discourse analysis (DA) has been suggested as useful when exploring MH because it allows us to question 'taken-for-granted' understandings, takes a non-traditional research strategy and values human and theoretical diversity (Harper, 1995). It therefore provides a useful basis for exploring the identity construction of MHPs-MHSUs.

There are two empirical studies that explore the identity construction of MHPs-MHSUs from a social/DA perspective. Adame (2011) explored 11 psychiatric 'survivor' psychologist's relationship between their identities and the implications of identifying with different discourses. Participants had strong 'survivor identities' and felt their two identities ('survivor identity', 'professional identity') complemented one another. They spoke about the risks/benefits of self-disclosure, and were selective due to experiencing stigma, isolation, questions regarding their competence, and not being seen as a 'real' survivor when disclosing their 'professional identity' to psychiatric survivors. They spoke about their 'survivor identity' positively and negatively influencing their work and spoke about the use of 'them and us' dichotomies, influenced by hierarchal power. Adame (2011) suggested that participants got drawn into the rigid discourses from either side, especially as they did not conform to what others expected of them.

Joyce et al. (2007) explored the workplace experiences of 29 nurses with MH problems and found that participants' identity shifted from 'nurse' to 'patient' as they became more aware of human vulnerability. They spoke about the positive and negative experiences from colleagues. Some felt that the 'patient role' was sometimes imposed upon them by colleagues, whereas others spoke about being assertive, knowing their rights and challenging

the beliefs that someone with a MI is incapable. Most participants spoke about the experience of being a nurse with a MI as a negative experience, not conforming to normality, therefore experiencing discrimination.

Other studies have explored the experience of MHPs-MHSUs and found that they experience dilemmas (Berry, Hayward & Chandler, 2011; Cain, 2000; Charlemange-Odle, Harmon & Maltby, 2012; Gilroy, Carroll & Murra, 2001; Lindow & Rooke-Matthews, 1998; Stanley, Manthrope & White, 2007; Van Erp, Hendriksen-Favier & Boer, 2010), including issues regarding self-disclosure, experiencing stigma/prejudice/discrimination, feeling devalued and not taken seriously, being accused of over-identification and boundary violation, having reduced energy, confidence and emotional presence, experiencing negative reactions from colleagues, self-criticism and a discrepancy between their identity and their professional role. Participants felt that their MHSU experiences added to their work, including useful self-disclosure, increased emotional empathy/insight, the ability to hold hope for clients and experiencing positive reactions from colleagues.

The literature suggests that MHPs-MHSUs experience some positive effects, but the majority experienced dilemmas when constructing their identities. It could be assumed that these dilemmas arise because MHPs-MHSUs are trying to construct an identity drawing on different discursive resources with different power implications (Parker, 1992; Sampson, 1993). Therefore they are drawing on contradictory discourses (Billig et al., 1988; Billig 1991) making their identity difficult to reconcile. However these studies have methodological limitations. Only two of the studies documented their analysis process and results were based on individual perspectives and the authors' analysis/interpretation at a specific point in time, within a given context, leaving unanswered questions regarding the quality of the findings. They used small, self-selecting narrow samples, and the results could have been affected by self-report bias.

Rationale

Despite the growing numbers of MHPs who are beginning to disclose their MH service use, theoretical, empirical and clinical knowledge of how they construct their identity is limited, with a lack of awareness of the powerful relationships and influence of social structures. Research suggests that MHPs-MHSUs may experience a range of dilemmas, however there is limited research that explores how they manage these and how this impacts on their identity construction.

This study aimed to address this gap in the literature by exploring how MHPs-MHSUs construct their identities from a social constructionist epistemology, extending existing research taking into account some of the methodological limitations. Research now acknowledges the importance of language and by exploring how people 'talk' about their identities, by looking at the discourses drawn upon by MHPs-MHSUs, we can explore and describe the range of discourses and identity constructions available to these people; how they position the speaker and what they achieve for the speaker.

It seemed timely to investigate this due to current policy calling for lived MH experience in MHPs. It will add to the limited literature in this area and allow for any new discourses to be systematically documented and heard more widely. This will have implications for practice in relation to the personal and professional development of MHPs-MHSUs, it may help deconstruct the idea that MHPs are 'superhuman' (Deutsch, 1985; May, 2001) and develop a professional ethos that places more value and focus on self-care of all members. It may provide useful information about the interface between MHPs and the services within which they work, how different service contexts lead to different constructions and colleague interactions. It may increase people's awareness of how MHSUs are viewed and may therefore serve to erode away some of the barriers between MHPs and MHSUs (Stanley et al., 2007).

Research Questions

Drawing on the DA approach by Parker (1992) and Willig (2008), the study addressed the following research questions;

1) How does a sample of MHPs-MHSUs construct their identity in different professional contexts?

2) What discursive resources are available to them when constructing their identities, exploring the wider discourses that these constructions are drawing on?

3) Is it possible to identify newly emerging discourses?

4) For each kind of construction identified, the researcher explored the social consequences of constructing these identities in different ways:

   - How this 'positions' the participants.
   - How it facilitates or constrains social action.
   - The relationship between the discursive resource and subjective experience.

Method

Participants

The study included ten participants; five male, five female; seven white British, two Asian and one South African. Participants were from different professional disciplines including art therapy, nursing, management, social work, peer work, psychology, occupational therapy and psychiatry. Participants had all used out-patient MH services; some had used in-patient MH services, for difficulties including depression, suicidal ideation, paranoia, schizophrenia, bipolar disorder, psychosis, anxiety and bulimia. Participants had different time scales since their diagnosis/last episode, ranging from 15 years to one year. Eight participants considered themselves to have on-going difficulties, with one participant

currently taking anti-psychotic medication. Eight participants were currently working; four full-time, one part-time and three participant's working hours were unknown. Two participants were currently not working. Four of the participants were MHSUs before becoming MHPs and six were MHPs before they were MHSUs.

Ethics

Ethical approval was gained from Stanmore Research and Ethics Committee (REC) (appendix G) and Research and Development (R&D) approval was obtained from a local NHS trust (appendix H). British Psychological Society and university guidelines for conducting research were adhered to. Informed consent was gained from participants. Annual study reports were sent to the REC (appendix I) and ending reports were sent to the REC, R&D and participants (appendix J).

Design

DA allowed for a detailed exploration of the language/discourse available and used by MHPs-MHSUs, and how this impacts on their identity construction in different professional contexts. Interviews allowed for complex information and diverse forms of expression to be gathered. The data was analysed using a combination of the two main DA approaches; Foucauldian DA and discursive psychology. This enabled attention to be paid to both the negotiation and construction of meaning through language in everyday social interaction, achieving interpersonal objects i.e. identity (Wetherell, 1998; Willig, 2008) and the consequences of wider social and institutional discourse that are available for people to draw upon (Potter & Wetherell, 1995; Willig, 2008).

Interviews

All interviews involved gaining written consent (appendix K), conducting the interview following the semi-structured interview schedule (SSIS; appendix L) and debriefing participants. The SSIS was developed using interview guidelines and reading of

the literature (Drever, 2003; King, 2009). It was reviewed by the University Research Panel, project supervisors and piloted. Interview topics included questions related to professional role, MHSUs experience, MHP-MHSU experience, professional contexts and how participants/others talk about their identity. Interview recordings were transcribed and analysed.

Procedure

Participants were recruited using an advertisement (appendix M) which was distributed in NHS services, MHSUs groups, recovery networks and a trainee clinical psychology cohort, from which snowballing occurred. Participants were asked screening questions in order to check that they met the inclusion criteria, were given participant information (appendix N) and were given time to decide whether to take part. Interviews were conducted in MH services, participants' homes or university premises and lasted on average one hour and 28 minutes. Participants identified themselves as being MHPs (all professionals currently working or having worked in a professional caring role within the NHS, voluntary sector or privately) and MHSUs (someone who has had no choice but to use mental health services at some point). These definitions were chosen in order to gain a broad range of self-identifying MHPs-MHSUs, reducing the likelihood of imposing a discourse onto participants. Participants had to be employed within the last 18 months in order to be able to talk about their MHP-MHSU experiences in a professional context. Those with communication problems, non-English speakers or in a crisis were excluded.

Data Analysis

The transcripts were analysed using the methodology recommended by Willig (2008) in order to;

1) Find the discursive objects in the text – Transcripts were read and re-read in order to find the discursive objects in the text, i.e. times when the participants referenced to themselves or their identity as players/social actors.

2) Explore the discursive objects' construction – When participants referred to themselves or their identity these constructions were explored to see how they were formed, their variability within the different contexts and whether there were any conflicting repertoires/discourses.

3) Situate the discursive constructions within wider discourses – Participants identity constructions were situated within wider discourses by exploring which discursive resources were available to participants from wider discourses and which wider discourses their constructions were drawing upon.

4) Explore the function, consequences and implications of the discourse – For each identity construction the following questions were asked, what is/is not gained, what does it/does not allow, what it its function, what it is in response to, what does it emphasise, how does it position them and does it enable/disable social action?

5) Explore the relationship between the discourse and the subjective experience – For each identity construction the subjective experience was explored, in what could be felt, thought and experienced within these constructions.

25 published written personal accounts were also analysed. The analysis of these accounts was less thorough than the interview transcripts as the aim was to investigate whether previously identified discourses would also be present and whether any new ones would emerge in the written accounts, in order to validate/substantiate the overall analysis (appendix

O). Ten written accounts were excluded from the analysis as they were either presented at conferences, unavailable or autobiographies.

Quality of the Analysis

It is acknowledged that the results are one interpretation of the texts and that there are alternative ways in which it could be read. The researcher took steps to ensure quality of the results following the guidelines of Mays and Pope (2000) including conducting respondent validation (RV; appendix P), providing a clear, transparent audit trail (appendix Q), keeping a reflexive research diary (appendix R), paying attention to data that contradicted initial impressions, allowing supervisors to review the data/analysis periodically to investigate biases, conducting triangulation and making sure the research design incorporated a wide range of different perspectives allowing for many viewpoints to be represented.

Results

Participants constructed their identities in many different ways in their professional contexts. They constructed their identity drawing on two main separate identity constructions; 'professional identity' and 'patient/MHSU identity'. What occurred throughout the text, was that participants drew on, presented or had separate identity constructions imposed upon them, that made them switch between them, therefore developing an 'un-integrated identity' construction. They also developed some sense of an 'integrated identity', where they were able to draw on all their experiences.

Participants drew on a wide range of discursive resources to construct their identities and presented their different identities to differing degrees depending on the professional context within which they found themselves. This section will begin by exploring participants' separate identity construction and will then move on to explore participants' 'un-integrated identity' and 'integrated identity' constructions.

Separate Identities

'Professional identity'.

Participants spoke about their disciplines, role and jobs and had a sense of belonging/identifying with a particular professional group: 'It's a very large…part of my identity…I do spend a lot of time um, doing occupational therapy….it's a big part of my life' (Claire [1]). 'I see myself as a psychiatrist' (Helen). 'It's a sense of belonging' [mental health nursing] (Paul).

Participants drew on a 'professional discourse' when talking about their profession and did not clarify terms, as if aware that they were talking to another MHP. The 'professional discourse' was made up of a 'psychological discourse' and a 'medical/psychiatric discourse'. Participants drew upon psychological/medical terms and phrases when talking about their profession and MHSU experiences: 'I guess this service, much more based in a kind of continuum model of psychosis, and very much a kind of like normalising some of these experiences' (Sarah). 'Intergenerational split…internalised…transference…regression…reintegrated' (William). 'Depression is like an illness, like…a physical illness, like possibly diabetes…it is a treatable illness, so yes I do see it as an illness' (Helen). 'I was on Olanzapine...I was on Fluoxetine….I was on Citalopram' (Chris). Research suggested that viewing MH problems in a medical way, i.e. as 'an illness' is problematic. Angermeyer and Matschinger (2003) found that diagnosis develops a negative stereotype of MI leading to beliefs that an individual is dangerous and increased discrimination, leading to fear and social distance.

Within this 'professional identity' construction, MHPs were viewed as knowledgeable, valued, useful, competent, responsible and therefore powerful. They were viewed as 'experts' and listened to by others, leaving themselves to feel wanted and special: 'My identity as a psychologist was I am superior' (John). 'A highly qualified

[1] Names have been changed to protect anonymity

professional…very competent' (Jo). Within this position MHPs hold power over those they treat. For example, drawing on a 'discourse of medical power' they hold power over MHSUs and are afforded the task of diagnosing/treating. Participants spoke about hierarchy within the profession that affords senior, more powerful, medically dominated professionals more involvement in decision making, leaving those less senior feeling powerless and de-valued: 'Nursing staff in particular are very closed down by their hierarchy traditionally, some get in places where they can operate but…they are quite threatened and ruled by fear' (Claire). 'You're [HCA] at the bottom of the food chain…you're not even noticed' (Mohammed).

Within this 'professional identity' construction participants drew on an 'achieving/academic discourse'. The idea that in order to be a MHP you have to be academic and have significant achievements, adding to the idea that MHPs are knowledgeable and have expertise, which affords them authority: 'I've done a lot of training myself, um professional development work' (John). 'I went to university and studied psychology' (William). For some this was a demanding/pressured position because there was a sense that you need to achieve to be a MHP. This led participants to develop anxiety and fear of being judged, leaving them to feel not good enough: 'I realised I had messed up…my grades were…no way near good enough to get into clinical psychology' (Mohammed). 'I can't do this [PhD]…I just started feeling really anxious and really depressed' (Sarah).

Participants drew on a 'discourse of expected/disallowed ways of being' when constructing their 'professional identity'. Participants spoke about it not being acceptable to rant/rave and become angry as a MHP because you were expected to be diplomatic, work within policy restrictions and adapt/comply with the identity of a MHP, imposed on them by others. For some it felt as though being a MHP was like putting on a mask/acting. Having these restrictions left participants feeling powerless because they felt that they had to adhere to them: 'If I was in a meeting I would put on the professional face' (Chris). 'If I am in a

meeting with a very senior psychiatrist, I will keep my gob shut and almost pretend to go along with their stuff'' (William).

All participants drew on this 'professional identity' construction, particularly when talking about working within professional contexts. As illustrated by the more subversive tone of William, a few participants spoke about rejecting their 'professional identity', possibly as a way to make sense of all their experiences. However, this meant that they were no longer identifying with the powerful majority and instead risked being judged and viewed as incompetent because they were no longer viewed as knowledgeable/'expert': 'I'm unusual in that…I publicly say that I have recovered from all my academic and professional trainings. Some people find that funny…some professionals get angry when I say things like that particularly at conferences…they will say…what's your background young man' (William).

'Patient/MHSU identity'.

Participants constructed their identity as belonging to that of a 'patient/MHSU identity', drawing on the wider 'patient/MHSU discourse', influenced by the 'medical/psychiatric discourse'. Participants spoke about their negative/bad experiences of being MHSUs and having a MH problem, suggesting that people did not want this identity, did not speak about it and wanted to conceal it because it is stigmatised. Some participants spoke about being made to feel/behave like a MHSU: 'I have been a service user, I have used a psychiatric service um, and I am very comfortable with it' (Helen). 'I myself became a mental health service user' (Mohammed). 'People think it is negative all the time…oh god don't talk about it, don't think about it, put it away, it's done with, finished' (Anna). 'What's the identity…of a schizophrenic…on the news you are a serial killer…you're a person who's going to flip out…that is people like me because they are made to feel like that' (Chris).

There was a rhetorical device, drawing on the 'discourse of medical power' that someone in a position of authority, i.e. MHPs needs to tell MHSUs they are unwell, label and

treat them, as if there is a mystery surrounding MH problems that only MHPs are aware of. Therefore this identity was often imposed by others in a position of power: 'My supervisor um, noticed that um, I was unwell' (Helen). 'The GP um, gave me, started getting me on pills, antidepressants and labelled me with depression' (Chris).

Constructing the 'patient/MHSU identity' in this way, suggests that those occupying this position are powerless, weak, fragile, devalued, disempowered, judged, subservient, incapable and untrustworthy. Due to this limited power MHSUs are viewed as having fewer rights or choices, they lack control and are required to comply with care enforced on them by those in positions of power. Individuals within this position are likely to hold negative views about themselves and feel hopeless about the possibility of change: 'I was completely disempowered and not believed on the basis that I was ill' (Claire). 'Everything I did when I was sitting totally in the service user role and identity didn't have value' (Jo).

Within the 'patient/MHSU identity' construction, participants spoke about an on-going recovery journey, drawing on a 'personal recovery discourse', grounded in the ROC ideas: 'Massively surreal, kind of journey, but it has made me determined' (Anna). 'I sometimes struggle with my own anxiety…the whole thing isn't going to die overnight' (William). Drawing on the 'personal recovery discourse' appears to construct a more positive 'patient/MHSU identity' because it acknowledges on-going MH difficulties, however reframes it as a journey rather than a 'stuck' position. By constructing it in this way MHSUs have gained the chance to recover, they can therefore be viewed as more capable and have more power to be involved in their care, increasing the individual's autonomy and self-esteem/confidence.

Within the 'patient/MHSU identity' construction, participants drew on an 'anti-psychiatry/organisation/professional discourse'. Participants spoke about disagreeing with the dominant medical model, the labels/treatments they had received and with professional

practices and service structures: ‘It’s all this mental illness is a physical thing…chemical imbalance…show me the brain scans of these people…show me that their chemical imbalance has been tested and that they’re being treated for their chemical imbalance…you can’t do it’ (Chris). ‘It seems to be full of bullying, you know, full of people that are incredibly mean to…service users’ (Paul). ‘It [professionalism] all becomes material to justify their existence, to justify their diagnosis’ (Mohammed). Participants drew on an ‘anti-psychological therapy discourse’ and used the word ‘you’ as if using rhetorical devices specifically aimed at the interviewer: ‘Not those crappy words that you use. Just human conversation, like I don’t do all this, you sit here, I sit there business’ (Chris). Taking this radical/opposing position means that either something new can be created or, especially if a minority opposes something powerful (the medical model, therapist dominance) they risk being ignored/dismissed: ‘Sometimes my work goes down like the Titanic, sometimes a lot of people like it’ (William). ‘It rocks the boat’ (Claire).

Participants who drew very strongly on the ‘anti-psychiatry discourse’ appeared to feel as though they had been victims of the MH system; having things done to them by professionals, who label/forcibly ‘treat’ them. They described surviving the MH system, drawing on a ‘survivor discourse’ and some developed a ‘survivor identity’: ‘I found them…[psychiatric wards]…more traumatising than my original trauma I was trying to manage…they compounded my trauma even more, predominantly by…forced medication, being detained…stripped…beaten…kicked’ (William). ‘As a survivor’ (Jo).

Even though participants drew on an ‘anti-psychiatry discourse’ and disagreed with labelling/diagnosis, they also drew on a ‘discourse of needing labels’, in the sense of needing words to describe/understand experiences: ‘We do need to have some kind of…words to describe things’ (Anna). ‘In the past I have felt reluctant to use those kinds of words [anxiety, depression] because I haven’t felt like I’ve earned them’ (Sarah).

All participants drew on this 'patient/MHSU identity' construction, particularly when talking about their MHSU experiences. A few participants spoke about rejecting their 'patient/MHSU identity', possibly as a way to make sense of all their experiences and discarding a stigmatised/devalued/invalidating identity. Therefore for some there is the possibility of rejecting an imposed identity and questioning those in more powerful positions: 'I didn't accept that I had a mental illness and that was what was wrong with me' (Chris). 'Why do I have to accept a label that someone else is putting on me…they do feel like outside labels which don't fit me or the identity I was to forge' (Jo).

'Un-integrated Identity'

Participants developed an 'un-integrated identity' construction and spoke about finding it difficult to be a MHP-MHSU. What occurred throughout the text, was participants drew on, presented and had the above separate identity constructions imposed upon them in a way that they were either/or, depending on given contexts. This meant that participants moved from one to the other or switched between them, developing an 'un-integrated identity' construction: 'You've got your professional hat on…you can switch into your user hat' (Claire). 'The service user part, the psychotic part, the confused part and whatever part somebody else tells me' (John). One participant noted that he felt good about this, but for the majority of participants it seemed problematic.

Within the 'un-integrated identity' construction participants drew on the discursive resources describe above. However, because the identity construction of MHPs and MHSUs are viewed as fundamentally different within society, these two identity constructions do not come together easily, therefore dilemmas occurred leading to un-integration. Participants spoke about MHPs and MHSUs being viewed as different, setting up a 'them and us' divide, with the MHPs being the 'good' identity and the MHSUs being the 'bad' identity: 'That's a different identity [MHP and MHSU]…a totally different world, they are different people'

(Jo). ‘Having had experienced some of the darkest and deepest forms of distress…a mad man versus someone…got a reputation for being highly professional…they’re worlds apart unfortunately’ (William). The alternative ‘them and us’ divide can also occur when MHSUs hold a ‘survivor identity’, drawing on an ‘activist discourse’ with other MHSU (Weltz, 2003).

As society views MHPs and MHSUs as different, you cannot occupy both positions, i.e. you cannot be unwell/vulnerable as a MHP. This was represented by participants talking about being viewed as unable to do their jobs whilst unwell. Some felt they lost their ‘professional identity’ when they became unwell, some held the view that MH services were not well equipped for professionals with MH problems, some felt that MHPs, including themselves held negative views about MHPs-MHSUs and felt that awareness of MHPs-MHSUs was non-existent: ‘There is nowhere to be if you are feeling fragile…the message is don’t come into work because if you can’t cope with what’s in front of you, you have no business being there’ (Paul). ‘They might judge me and say, oh you shouldn’t be seeing clients’ (John). ‘In terms of anybody acknowledging my experience as anything valuable was non-existent’ (Mohammed).

Participants may have be drawing on conflicting repertoires/discourses that are dilemmatic, i.e. drawing on an ‘anti-professional discourse’, whilst identifying as a professional. Participants spoke about this being a hard position to occupy and felt that they were viewed as different, were not listened to and therefore felt judged and powerless. They spoke about having to hide certain parts of themselves in certain contexts, because they were seen as unacceptable and sometimes being pushed to behave in certain ways: ‘I think being a health professional and being ill, a service user…is probably…the hardest thing’ (Paul). ‘Why am I being forced to either go professional or service user or carer’ (Jo).

Within this ‘un-integrated identity’ construction participants spoke about the service user movement (Frese & Davis, 1997), drawing on a ‘service user movement discourse’.

Participants spoke about valuing, supporting and admiring their work professionally, as well as speaking about their own involvement from within their 'patient/MHSU identity': 'It [working with MHSU] meant um, learning from my colleague, service user… it made me even more comfortable…with my illness because you know these people had done remarkable things, had managed to keep themselves well in spite of…all problems' (Helen). 'I became involved in a mental health service user group…gave me recognition of who I was at the time…really was about empowerment, knowledge umm skills, recognition, action' (Jo). Drawing on the 'service user movement discourse' could be viewed as a radical position, opposing the 'discourse of medical power', which runs the risk of being shut down by those who are more powerful. However, it could also lead to new learning that values 'lived experience' and allows MHSUs to speak where they may have been previously silenced. This would involve a more equal distribution of power between MHPs and MHSUs, affording MHSUs more value and involvement.

Participants also drew in a 'use of self discourse' within this 'un-intergrated identity' construction. Participants drew on this from a 'professional identity' construction, drawing on a 'professional discourse' to suggest that there was a rule that MHPs-MHSUs were not allowed to discourse their MH problems to their patients as this would be inappropriate/unprofessional: 'You have to be very careful about keeping what's yours and what's theirs clear' (Anna). 'I mean the focus is on them, so it's not sort of me, oh by the way, guess what, this is what happened' (John). Participants did not disclose their MH problems within their professional contexts or only spoke openly to a few colleagues or within a particular context when they felt safe to do so: 'Some people know about my um, experiences of being unwell and being in hospital, some people don't…I'll do it in a way that I feel safe' (Anna). 'I was told…by a couple of colleagues…you never disclose this again, you don't talk about this to your colleagues, people take advantage' (Mohammed).

Participants were again silenced and had to hide part of their identity, developing separate and 'un-integrated identities'. Participants were aware of other MHPs-MHSUs who did not disclose their MH problems; 'I knew that there were other people…later on I realised that she was an anomaly and not everyone else did share, even though they kind of professed to' (Sarah). For some there was also a sense that if they disclosed their 'professional identity' with a group of MHSUs they were viewed as not being 'real' MHSUs: 'I get accused of being a super user…a derogatory…term used by other service users about service users who have a paid job' [in MH services] (Jo).

All participants spoke about the dilemmas of being MHPs-MHSUs, therefore developing an 'un-integrated identity' in their professional contexts, especially when they felt uncomfortable or uncertain of themselves. They were drawn into different positions by those around them, leading to this switching action between their separate identities. Participants felt that a more 'integrated identity' would be better: 'I have got problems because I haven't managed to integrate fully both roles and feel comfortable in different environments' (William).

'Integrated Identity'

Participants constructed their identity as an 'integrated identity', however for some this was a less formed and/or spoken about identity than the 'un-integrated identity' construction. Within this 'integrated identity' construction participants were able to draw on all their experiences, which were viewed as equally important and complementary: 'I don't feel that I need to demarcate, differentiate…I think both my roles…my experiences have contributed to me becoming who I am' (Helen). 'What makes me, me is a combination of all of those things' (Anna).

Within this 'integrated identity' construction participants drew on a 'wounded healer discourse'. They spoke about going into the profession because of their own experiences of

'distress'/caring and used their professional knowledge to make sense of their own MH experiences and when accessing MH services themselves: 'I think a lot of people go into mental health because they have a personal affinity um, for it anyway because of their um, insights of their own thoughts' (Claire). 'I think that [a continuum model] was a useful way of understanding some of the difficulties I had had in the past' (Sarah). Some participants felt that it was important for those working within the field to have experienced some level of mental 'distress' in order to fully understand/be able to work with MHSUs: 'If someone doesn't have any idea about what it's all about and they have just read it…and they haven't experienced what it's like…they are not very informed about what it's about' (Chris).

Within this 'integrated identity' construction participants drew on a 'lived experience discourse', drawing on their MHSU experience within their professional role, to more effectively help/provide better care to MHSUs: 'I've got a lot of compassion for people because I can recognise that these thoughts that they are believing…I can really support them in this…I'm not scared to work with really disturbing thoughts of a client….because I had pretty disturbing ones myself' (John). 'In fact they come to you and talk to you even more, they are more open to you than they are probably to the nurse or psychiatrist' (Mohammed).

Participants drew on the 'discourse of use of self', however unlike the 'un-integrated identity' construction participants spoke about being able to disclose their personal experiences of MH problems to colleagues and MHSUs, linked to a 'coming out discourse'. However there is still a tension, in relation to how others perceive MHPs-MHSUs and participants spoke about receiving a mixture of positive and negative responses when disclosing: 'So that [writing a paper] was in a way me coming out' (Helen). 'It's been over quite a long period of time….they were like, ok, yeah that's fine' (Paul). 'They didn't know what to say and they are psychologists and psychiatrists…it was really awkward' (Sarah).

‘It’s opened up doors for patients…to be able to return something to me like, oh how are you in yourself and I understand you…they feel validated’ (Claire).

Within this ‘integrated identity’ construction participants normalised their experiences of MH problems and spoke about their identity as being nothing special, drawing on a ‘normalising discourse’. This meant that participants could now view their MH problems in a more positive light: ‘It’s just me, it’s just who I am’ (Paul). ‘All human beings at some point have been confused’ [confused – his word for psychosis] (John). ‘In a way I feel quite privileged that I have had this experience’ [MH problem] (Helen).

Drawing on these discourses enabled participants to draw on their personal and professional knowledge/experiences whilst in their professional role in an integrated way, allowing for new skills and perspectives to develop and be valued. This potentially affords individuals occupying this position a space to speak and get their needs met, when they previously may have been silenced or not found a way to draw on all these experiences. This may enable them more power, allowing them to contribute more fully to discussions/decision making. This ‘integrated identity’ construction afforded participants the opportunity to do something different and challenge existing practices, drawing on an ‘activist discourse’: ‘Things don’t progress unless you…challenge existing practice, and I’m not doing it in a ridiculous way’ (Claire). ‘I feel that I am on a bit of a path to change things um, and it’s quite refreshing to do something that certainly, in my profession, hasn’t been done before and to be part of that is really fantastic’ (Anna).‘Another motivating factor for me in doing it and this is kind of my activist role’ (Sarah). Participants from this position appeared to be able to engage in positive social action at an individual level, i.e. making small changes to their practice, and at a wider level, where participants were afforded certain opportunities including writing personal accounts in professional journals (Anna and Helen), employing/supporting MHPs-MHSUs (William and Paul), engaging in/conducting relevant research (Claire, Paul, Anna,

Mohammed, Jo), becoming involved in MHSU groups (Sarah, Mohammed, Jo and Anna) and representing MHSUs and MHPs-MHSUs voices within their professional role (Anna). Some participants spoke about feeling as though it was their duty/obligation/mission to take on an 'activist identity', making it a difficult position to take. Therefore, some participants felt as though they had little power against the powerful 'medical discourse' and were trying to pass the responsibility of change onto others, including the interviewer: 'I honestly think this is you guys, you're the next generation, I believe if anything…is to change…only what you guys will be doing in the future' (Mohammed).

For some participants they experienced many advantages of occupying this 'integrated identity' position, including feeling proud, stronger, driven, determined, passionate and valued: 'I do believe it's made me stronger um, certainly if you survive that kind of experience…really helps you put things into perspective' (Anna). 'It's like living a fulfilling life' (John). Whereas, for others it felt more like an 'infiltrator identity', in a way that they were being secretly rebellious and doing things under the radar, in the sense of a hidden, more 'un-integrated identity': 'I'm really proud to say that I am, unwittingly at times employed staff that have been service users in the past' (Paul). 'I've adapted enough to know when to keep my mouth shut or when to open it' (William).

From within this 'integrated identity' construction the 'them and us' barriers set up by more traditional MHPs and MHSUs identity construction could be eroded because MH problems were normalised: 'I am equal, I'm not better or worse than anyone, no matter where you look and I really mean everyone….that dropped the this whole barrier of being superior and then I can connect and be of service to all people, and I am friends with other service users and we support each other' (John). If equality were to increase MHPs would need to transfer some of their power/knowledge/value to MHSUs, and MHSUs would need to give up the limited power they have when taking the activist position, in order to accommodate the

position of their individual/unique expertise. This would mean that MHSUs views could be voiced and heard and they could be more active in their own and others' care. It may also mean that people could be more open about talking about MH problems, potentially reducing the stigma and allowing MHPs to not be viewed as 'superhuman' but to work within their limits.

All participants drew on an 'integrated identity' construction at times in the text; however for some this identity was not as formed and/or spoken about as the 'un-integrated identity' construction. Participants drew on a range of discursive resources to construct this identity; however they were not as widely used or strongly referred to as the other discursive resources. Most participants felt that an 'integrated identity' construction was the most helpful identity construction but acknowledged that it was difficult to achieve.

Published Written Accounts

Through analysing the written accounts, the researcher found the same identity constructions and discursive resources present as in the interviews, substantiating the overall analysis. Within the written accounts the 'anti-psychiatry discourse' and the 'survivor identity' construction emerged more powerfully: 'We were coached by professionals to learn to say, I am a schizophrenic…we were making progress because we learned to equate our very selves with our illness' (Deegan, 1996, p.4). 'I began to answer the psychiatrist's questions in a more acceptable manner…they were impressed with my 'progress'…I was a good hospital patient' (Bassman, 2001a, p.13). The authors use rhetorical devices in order for the reader to see what was done as acts of subjugation and the injustice of this. This positioned the author as having the power to criticise the practices that occurred, viewing them as unacceptable.

In relation to the 'use of self' discourse, the authors spoke about a sense of needing to earn your credentials before you can positively disclose your MHSU experience: 'Having

earned the 'credentials' and respect of my professional colleagues and peers, I have the opportunity to speak out' (Bassman, 2001a, p. 19). Zerubavel and Wright (2012) suggested that those later in their career may feel safer disclosing their personal experiences because they have shown their competence. Linehan (2011) stated that she waited to disclose her MH problems because she first needed to demonstrate the efficacy of dialectical behaviour therapy. Thus the 'use of self' discourse is not an easy one to adopt and one's capacity to use it positively may depend on time-served as a professional.

Within the written accounts authors drew on a 'personal recovery discourse' from within the 'integrated identity' construction, suggesting that being a MHP aids towards their own personal recovery: 'One of my major professional and personal milestones is my tenure in this position: three years. It sets a record for my shattered work history' (Tsai, 2002, p. 207). Within the 'integrated identity' construction, authors highlighted more powerfully the equality and reciprocity that can be developed between the 'professional identity' and the 'patient/MHSU identity'. They drew on a 'prosumer discourse', where both parts of the identity appeared equally valued rather than sources of knowledge: 'Many people readily see the significance of what I do for these individuals; however, most people fail to recognise the enormity of what these clients do for me' (Yarek, 2008, p. 1). 'I consider many of the consumers to be my 'friends', and the feeling is mutual' (Tsai, 2002, p. 206).

Discussion

The study aimed to explore how a sample of MHPs-MHSUs construct their identities. Participants were found to draw on different identity constructions including 'professional identities', 'patient identities', 'un-integrated identities' and 'integrated identities'. Participants drew on, presented or had the two separate 'professional/patient identity' constructions imposed on them, making them switch between the two leading to an 'un-

integrated identity' construction. At times participants drew on all their experiences, which were equally valued and complimentary, developing an 'integrated identity' construction.

Participants drew on a range of discursive resources to construct these identities, to differing degrees depending on their professional context. These identity constructions positioned participants differently dependent on which one they were drawing on, with some affording participants more power and social action, whereas others afforded participants less power and social action. Participant's 'integrated identity' constructions were less formed and/or spoken about, suggesting that the discursive resources drawn upon to construct this identity may be known but less used.

This research adds to the literature that suggests more MHPs-MHSUs are beginning to talk about their MH problems and MHSU experiences. This study found that the dominant separate identity constructions positioned MHPs as powerful/'expert' and positioned MHSUs as powerless/devalued. This corresponds to existing literature which suggests that within the dominant medical/psychiatric model (Walsh et al., 2008), MHSUs are positioned as being unable to recover and take control of their lives (Frese & Davis, 1997), developing a dominant 'mentally ill' patient identity (Schiff, 2004; Bassman, 1997; Frese & Davis, 1997) in contrast to MHPs who are positioned as having an 'expert' identity. However within the 'patient/MHSU identity' construction, participants were able to draw on a 'personal recovery discourse', enabling them to construct a more positive identity as suggested by the ROC literature (Shepherd et al., 2008; Oades et al., 2009).

This study provides evidence for the dilemmas faced by MHPs-MHSUs, as described in the literature, including the dilemma of disclosure (Schulze, 2007), the idea that MHPs are beyond distress (McCourt, 1999), negotiating the positive/negative impact of being a MHSU (Joyce et al., 2007), managing stigma/prejudice/discrimination (Adame, 2011) and facing 'them and us' dichotomies (Schiff, 2004). This study provides evidence as to how these

dilemmas impact on the identity construction of MHPs-MHSUs and suggests that in some professional contexts they have 'un-integrated' separate identity constructions and switch between a 'professional identity' and a 'patient identity' construction depending on the discursive resources available to them. This study also suggests the development of a new 'integrated identity' construction which participants were able to draw on in some professional contexts and suggests the discursive resources participants drew upon to enable them to do this. Providing evidence that MHPs-MHSUs identities can complement one another (Adame, 2011), and by systematically documenting this, less dominant discourses are drawn into the foreground, allowing them to be heard more widely, potentially challenging current dominant discourses. However participants stated that this was a difficult identity to negotiate and there was a sense that they easily get pulled back into an 'un-integrated identity' construction: 'Oh so you do know, oh you're one of us, oh right, and it just totally engages them, they feel validated' (Claire).

Limitations

The current study has limitations, including that participants were self-selecting making it difficult to transfer results to others who may have not come forward to take part in the study. The researcher conducted RV, however due to time constraints and the difficulty explaining DA to someone new to this methodology, feedback was limited. Harper (1995) suggested that DA runs the risk of 'over-interpreting' data and analysis not being sufficiently grounded, however efforts were taken to ensure the quality of the study. As previously reported the author acknowledged this is one possible reading of the data.

Future Research

Future research may wish to explore how MHPs-MHSUs construct their identity further and explore when and where these particular identity constructions occur. For example, exploring participants from certain professional disciplines, i.e. those more/less

informed by the medical model, different professional contexts, i.e. client/colleague interactions, professionals with different MHSU experiences, i.e. more/less severe, and of those who have 'come out' versus those who are hidden. This would be beneficial as it would help us understand within which contexts different identity constructions are likely to occur and the social implications of these.

Clinical Implications

This study provides useful information about the interface between MHPs and the services within which they work, and how ways of being can enable/disable social action. It is important for MH services and MHPs, including clinical psychologists, to be aware that MHPs-MHSUs exist and are becoming more vocal about their MH problems. This may help challenge the idea that MHPs are 'superhuman' (Deutsch, 1985), normalising MH problems and developing a professional ethos that places more value and focus on self-care of all members. With MHPs-MHSUs speaking out about their experiences, this may help erode some of the barriers between MHPs and MHSUs, increasing communication and developing new opportunities and relationships between people that would like to see change (Adame, 2011).

The study increases MHPs and services awareness of how MHSUs are viewed within society, which is particularly important for MHPs working with MHSUs therapeutically. It is important for MHPs to bear this in mind when developing services, and in order to reduce the power imbalance between MHPs and MHSUs, future work needs to involve MHSUs in the planning and delivery of services.

Conclusion

This study explored how a sample of MHPs-MHSUs construct their identities within their professional contexts. It suggested that MHPs-MHSUs construct, present, draw on and have different identities imposed on them in a variety of ways. Participants constructed their

identity as separate identities, i.e. a ‘professional identity’ and a ‘patient identity’, switching between them in different contexts, therefore developing an ‘un-integrated identity’. Participants also developed an ‘integrated identity’ in some professional contexts, however this was less formed and/or spoken about identity, which suggests that the discursive resources used to construct this identity are known but used less frequently. Clinical implications are documented and areas of future research suggested.

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Section C: Critical Appraisal

Word Count: 1995

Question One

What research skills have you learned, what research abilities have you developed from undertaking this project and what do you think you need to learn further?

I have learnt many research abilities through undertaking this project. I have developed skills in carrying out systematic literature reviews, drawing together, summarising and critically appraising a vast range of theoretical and empirical literature. I had limited experience in conducting qualitative research; therefore this project was a steep learning curve, which was exciting but also challenging, especially as discourse analysis (DA) takes a very different epistemological position to the traditional positivist methodology I had previously used. I therefore read around the theory and methodology of DA, allowing me to become familiar with it and develop my research questions. I explored discursive psychology and Foucalidian DA and after discussions with supervisors I decided that I would analyse my data using both approaches in order to explore the negotiation/construction of meaning and the consequences of this in terms of positioning and power, and to locate these constructions/negotiations within a society. Reading DA empirical studies and Willig (2008) steps for analysis enabled me to become familiar with the analysis process and develop a procedure that would limit more subjective readings of the data. Before and throughout the project I examined my reasons for engaging in this project and my assumptions. This included exploring my own beliefs about having a hidden disability (dyslexia) and the dilemma of disclosure, wanting to find the truth based on my positivist epistemological background and my assumptions about the identity constructions of 'mental health professionals' (MHPs) and 'mental health service users' (MHSUs).

I enjoyed reading about DA and feel this methodology brought richness to the study. As the project continued I learnt more about the importance of language, developed my linguistic skills and becoming more aware of the impact of subtle changes in language.

However because this methodology represents the multiplicity and variability of peoples constructions, at times it felt difficult to represent this complexity in a word limited paper, something that I developed and would learn to do more effectively if I continued using this methodology. There is also so much to learn and read about in DA, something that I would like to continue to engage in. I would like to continue to translate some of the linguistically challenging material within DA into more lay terms so that it can be received by a wider audience. I also feel that in order to broaden my understanding on qualitative methodologies it would be beneficial to develop my skills in other qualitative methodologies, such as grounded theory or interpretative phenomenological analysis.

I have learnt about gaining ethical approval. This was a very difficult process as there appeared to be confusion with which panel I should apply to bearing in mind that I was not just working with MHPs or MHSUs but both of these in the same person. Initially neither of the ethics panels would accept my project, which was very frustrating, but it made me reflect on whether this represented society's view of MHPs and MHSUs as two separate groups of people. This was useful material to take forward into my project and completing the application form and presenting my project to the ethics panel enabled me to clarify my research ideas.

I have learnt how to develop an interview schedule and conduct interviews. Piloting my interview schedule was a helpful experience, enabling me to practice my schedule and become more aware of my assumptions. I found that as I conducted more interviews I developed more confidence, which enabled me to explore things more clearly and develop more freedom to follow up participants' leads.

I learnt about recruitment and the importance of building links/relationships with people, in order for people to feel comfortable to take part in the study. In order to make these links I joined a group of ex-service users and carers who conduct research within an NHS

trust and a research recovery network, and presented my project at University. In these forms people expressed interest in my project, were willing to share my advertisement with others and volunteered to take part in my study. People felt that my project was interesting, new and relevant which was a real confidence boost and made all my hard work feel worthwhile.

Question Two

If you were able to do this project again, what would you do differently and why?

If I were to do this project again I would think more carefully about the implications of where I interviewed my participants. Interviews were conducted on NHS property, university premises and at participants' homes. On reflection I became aware of the implications of the interview context on the participants' interviews, what role they were most likely to be in in that context, whether this would enable/disable them from drawing on their other identities, the power implications of certain contexts and the impact this had on the identity constructions and discursive resources they were able to draw upon. I would have liked to have used naturally occurring discourse, in order to explore the identity constructions and discursive resources available to participants' whilst in different contexts. I also reflected on the power dynamics, with my role of being a trainee (lower status/power) and a researcher (higher status/power) and how this may have influence the participants, in relation to how open they could be about their experiences and how able I felt to ask certain questions. Using naturally occurring discourse would allow a range of different power dynamics with other people to be explored.

I would also conduct the respondent validation (RV) differently. RV is not traditionally used in DA due to the researcher's critical stance which in the past has offended participants (Garety, 1994; Walkup, 1994). However due to the number of participants who wanted to take part in the project, after discussions in supervision it was felt that RV could be conducted with a new group of six participants who were not interviewed but came forward

to take part in the study, as a way of gaining feedback without causing offence to the original participants. The analysis took longer than planned and I was late in disseminating the RV, therefore not all participants could respond. It was also difficult to explain DA to participants who have not come across it before and represent the complexity of results in a short summary, which led to some misunderstanding in the feedback received. In the future I would allow more time to conduct RV as I feel this is a valuable source of information.

A final thing that I would change if I conducted this project again would be to narrow the study down in order to clarify which identity constructions and discursive resources MHPs-MHSUs draw upon in specific contexts, in order to explore the contexts within which potentially more helpful identity constructions can be developed.

Question Three

Clinically, as a consequence of doing this study, would you do anything differently and why?

I really enjoyed conducting the interviews and found the participants insights interesting and a valuable perspective to have heard whilst training. I will certainly take away some of their ideas and use them in my future clinical work.

I have become more aware of how MHPs and MHSUs can be positioned, and how societal beliefs, underlying discourses, power relations and organisational structures influence this. I have already become more aware of the language that I and others use to describe MHSUs and mental health (MH) problems. I feel that using normalising language appears more helpful in breaking down some of the barriers that exist between MHPs and MHSUs. I feel that one way that I can help reduce the stigma of MH problems is by not adding to this view that MHPs are ‘superhuman’ (Deutsch, 1985) and acknowledge my own human vulnerabilities in my role as a Clinical Psychologist. I have begun to involve MHSUs more actively in my work at an individual level in therapy sessions, enabling MHSUs to take

a more active role in their care and I hope to involve MHSUs at a wider level throughout my career.

Throughout this project I have drawn parallels between my clinical work and this project. I had a six month placement predominantly working within a systemic/narrative therapy model. These models and DA both draw on a social-constructionist epistemology and explore societal influence on the stories we develop about our lives. I found it really helpful to have read the DA literature when working within these models and again became interested in the subtleties of language and talk as social action. I would like to continue working in this way, drawing theory-practice links and again involving MHSUs more actively in the formulation/therapeutic work which these models allow.

Throughout this project I have become more aware of the media and people other than MHPs speaking about their problems. The Division of Clinical Psychology (Kinderman, 2012) sent an email highlighting the Government's review of the MH strategy, in which three MP's spoke about their own MH problems. Gilchrist (2013) on a university blog, stated that celebrities such as Steven Fry are becoming braver at talking about their MH problems. This highlights that people in high powered roles are beginning to acknowledging their own vulnerabilities. However Gilchrist (2013) suggested that there is still stigma attached to MH problems and that disclosure is only the first step, which people need to think about carefully because of the messages that they are giving to people about MH problems. I would like to continue to explore these ideas, allowing them to inform my clinical work and I hope that by publishing my project, my findings can contribute to the debate.

Question Four

If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

There are several possible research ideas that could develop out of this current research project; however I will describe one research project that I am particularly interested in. This current project found that MHPs-MHSUs in some contexts can develop a more 'integrated identity' and appeared to construct this based on these known discursive resources; 'wounded healer', 'lived experience', 'use of self' and 'normalising, however these discourses were used less often than others and it appeared more difficult for some participants to draw on this 'intergrated identity' than the 'un-integrated identity' construction. Therefore I would be interested in conducting a research study that explores when/what allows MHPs-MHSUs to develop a more 'integrated identity', in order to explore the contexts within which potentially more helpful identity constructions can be developed.

I would want to explore which MHPs-MHSUs are more likely to develop an 'integrated identity', what this is based upon, i.e. profession, professional background/training, and in which contexts this is more likely to occur, i.e. more recovery/inclusive services. As DA has been a very useful methodology for this current project and this current study aims to extend its findings I would continue to use a DA methodology, however would take a more Foucaldian DA approach in order to explore the relationship between discourse and how people think/feel/behave and the consequences of this, in different contexts depending on the discursive resources available to them (Willig, 2008). I would also like to use naturally occurring discourse in order to explore what enables this 'integrated identity' construction to occur in different contexts. The aim of this study would be to explore what enables MHPs-MHSUs to draw on this 'integrated identity' because this current project highlights that this affords a more equal distribution of power,

may go some way to reduce the stigma associated with MH problems (Thornicroft, 2011) and reduce the ‘them and us’ barriers that exist between MHPs and MHSUs (Schiff, 2004). I would hope these findings might help to enable MH services to develop environments that encourage open expression of human vulnerability and develop a caring culture for all.

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Section D: Appendices of Supporting Material

Appendix A

Methodology

A systematic literature review was conducted in order to answer the following research questions.

- What evidence is there that there are ‘mental health professionals’ who experience mental health problems and/or, are/have been mental health service users?
- What issues might arise for their identity? A social constructions perspective.
- What evidence is there about how ‘mental health professionals’ who are/have been ‘mental health service users’ construct their identity?

In order to address these questions all major psychological, social science and medical database including; PsychINFO, Medline, ASSIA and Web of Science were systematically reviewed for relevant literature. There were many definitions that existed within the literature regarding this topic, which were held in mind when conducting the literature searches. The search terms (see literature flow diagrams) were chosen based on existing literature and were used in different combinations in order to retrieve the most appropriate resources to answer the individual research questions. If additional search terms were found during searches, additional searches were conducted and added to the final list of terms. The automatic start dates set by the databases were used as it felt appropriate to explore all available resources. Limits were placed to only receive papers in the English language.

Four individual systematic literature searches were conducted. Initially the paper explored the evidence that there were ‘mental health professionals’ who have mental health problems and/or are/have been ‘mental health service users’. In order to do this three separate literature searches were conducted based on how the literature defines those ‘mental health professionals’ who have mental health problems and/or are/have been ‘mental health service

users'. One explored the literature exploring 'distressed' professionals (Appendix B). Empirical research was included if it explored the 'distress' of 'mental health professionals' due to mental health problems. Another explored the literature on the concept of the 'wounded healer' (Appendix C). Empirical research was included if it explored the personal history of 'mental health professionals' in relation to the concept of the 'wounded healer'. Another explored the literature on 'mental health service users' employed in mental health services (Appendix D). Empirical research was included if they explored the identity or discursive resources available to 'mental health service users' employed in mental health services.

An overall literature review looked at 'mental health professionals' who are/have been 'mental health service users', from an identity and discourse analysis perspective (Appendix D). Due to the limited research this search was widened and empirical research exploring the experience of 'mental health professionals' who are/have been 'mental health service users' working in mental health services was included.

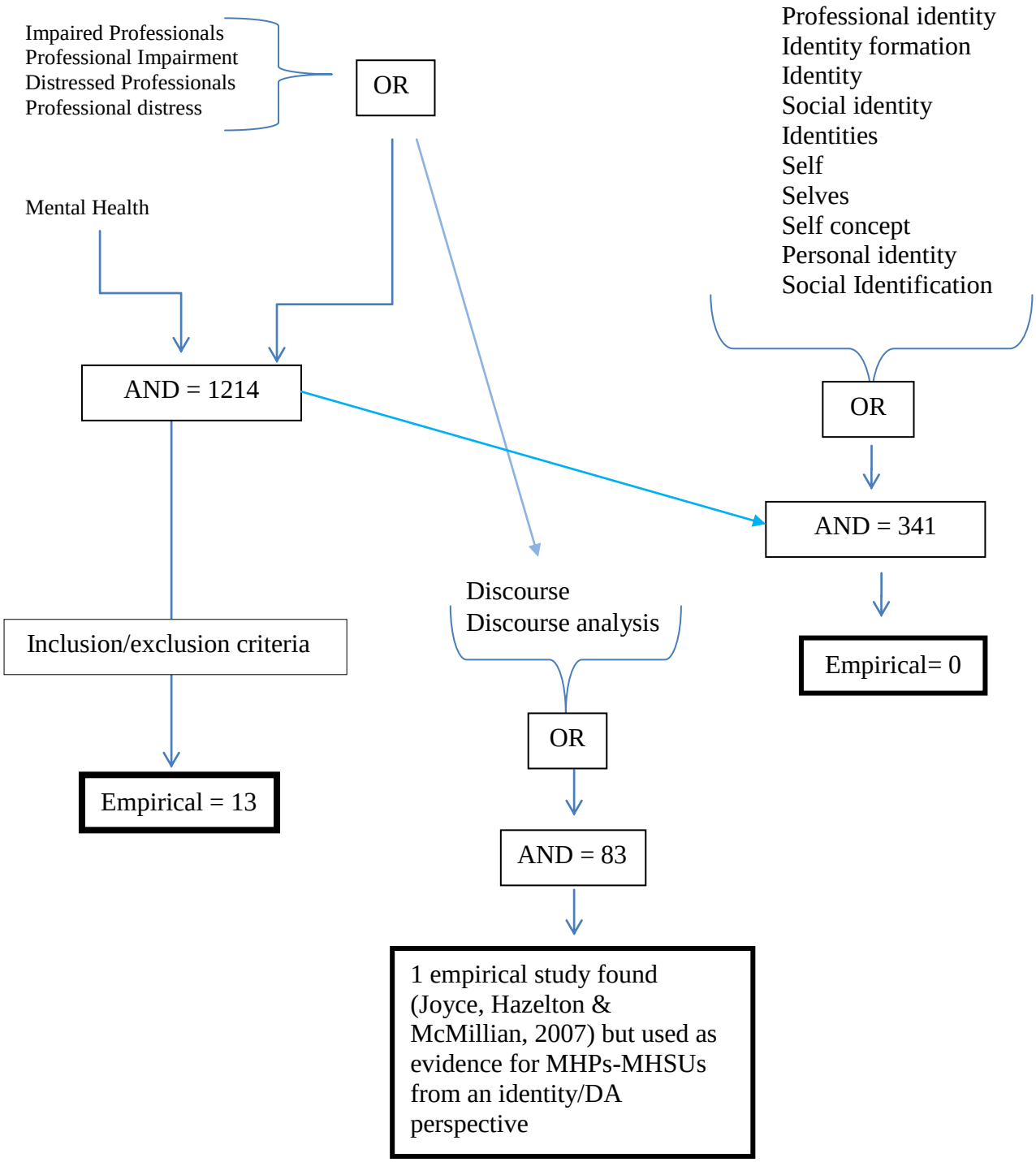
For all four literature searches empirical papers were excluded if they were dissertation abstracts, did not answer the research questions or did not meet the inclusion criteria. For example articles were excluded if they focused on problems other than mental health problems (e.g. substance misuse, physical, cognitive, health, visual, hearing and medical illness, palliative care, stress, grief, life crisis', marital difficulties, suicide and sexual misconduct), problems caused by being a 'mental health professional' (burnout, vicarious trauma, secondary trauma and post-traumatic stress disorder), professionals other than 'mental health professionals' (e.g. medical doctors, physicians, nurses, residents, health professionals, sports/school psychologists), trainee 'mental health professionals' rather than qualified professionals (e.g. trainee clinical psychologists, trainee psychiatrists), 'mental health service users' involved/participating rather than being employment in mental health

services, ‘mental health service users’ employment outside mental health services, articles that explore questionnaire validity/reliability, and articles that focused on outcome, treatment or help seeking behaviours.

Within each literature search all titles and abstracts were reviewed for relevant articles. Relevant articles’ references were reviewed for additional papers and key article citations and similarities were explored within the databases. The inclusion and exclusion criteria for papers led to a large number of papers being disregarded in order to only focus on papers the specifically address the research questions. Relevant conceptual papers were included in the contextual and theoretical parts of this paper. Qualitative articles were reviewed and assessed for quality using Mays and Pope (2000) and Yardley’s (2000) guidelines.

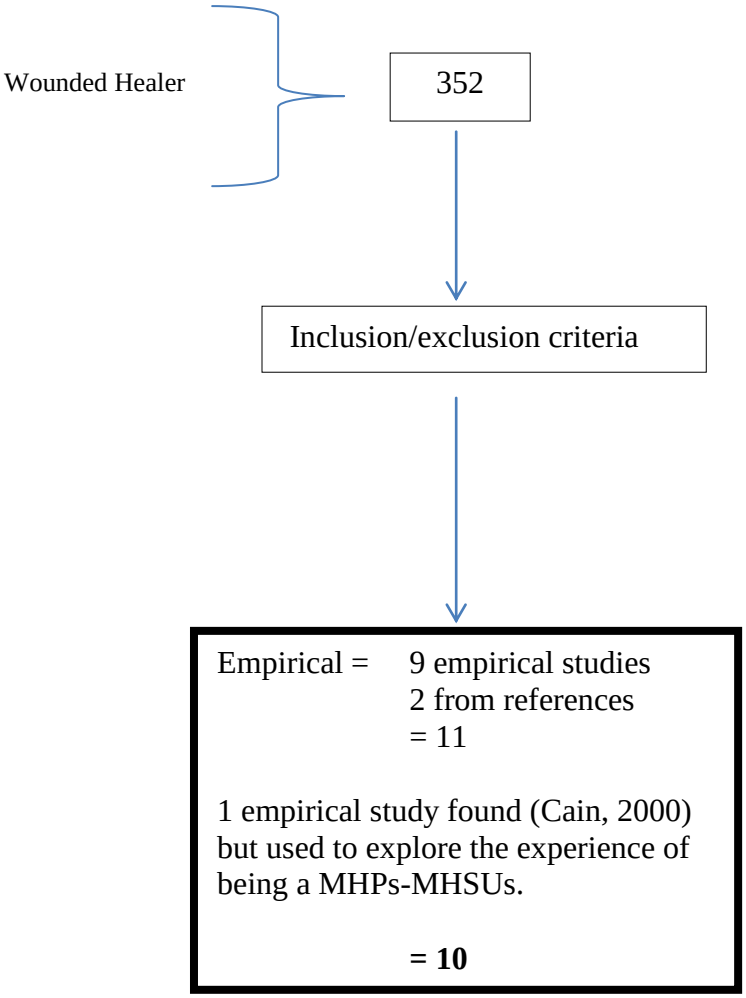
Appendix B

Literature Search Flow Diagram - 'Distressed' Professional



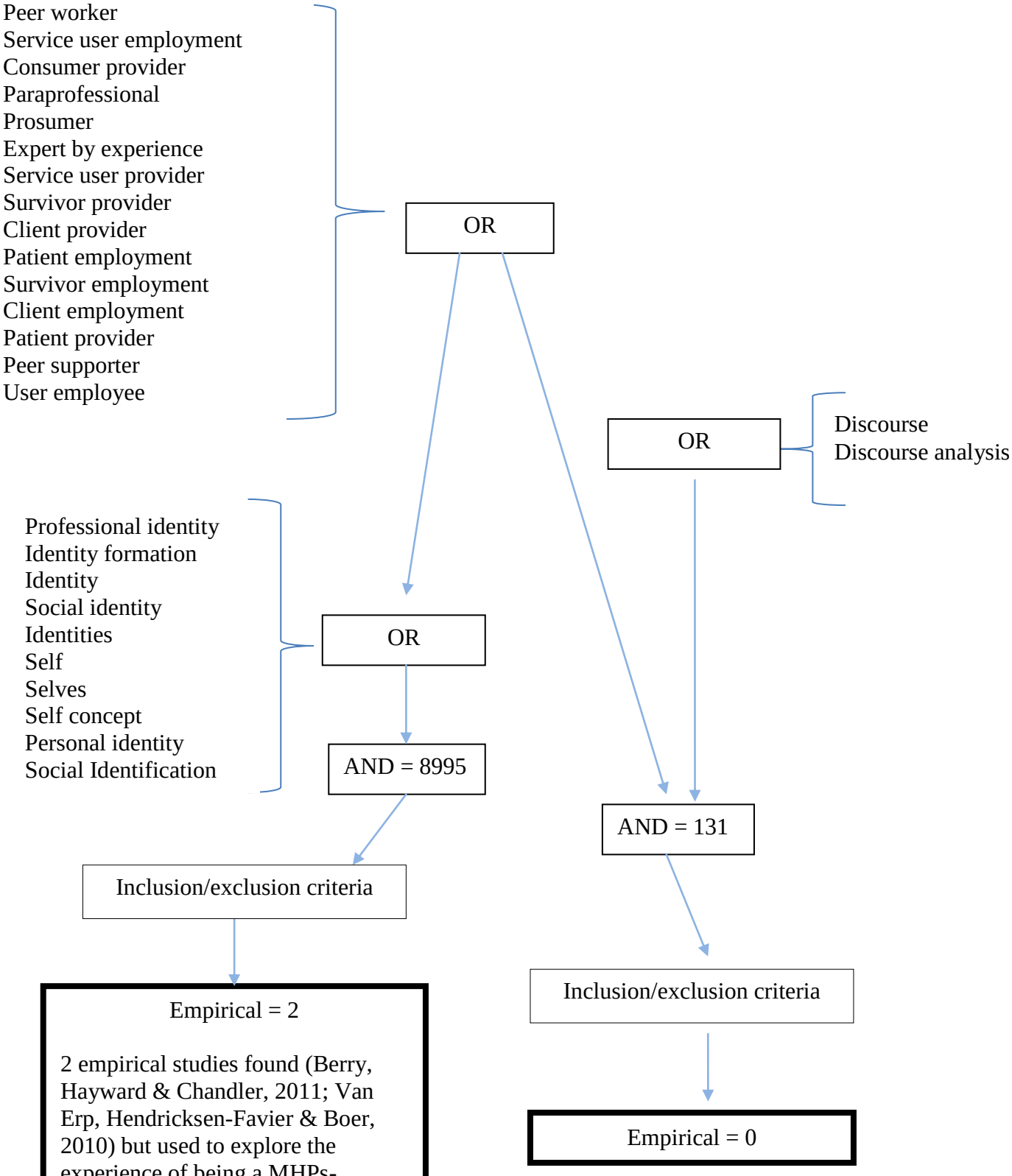
Appendix C

Literature Search Flow Diagram – 'Wounded Healer'



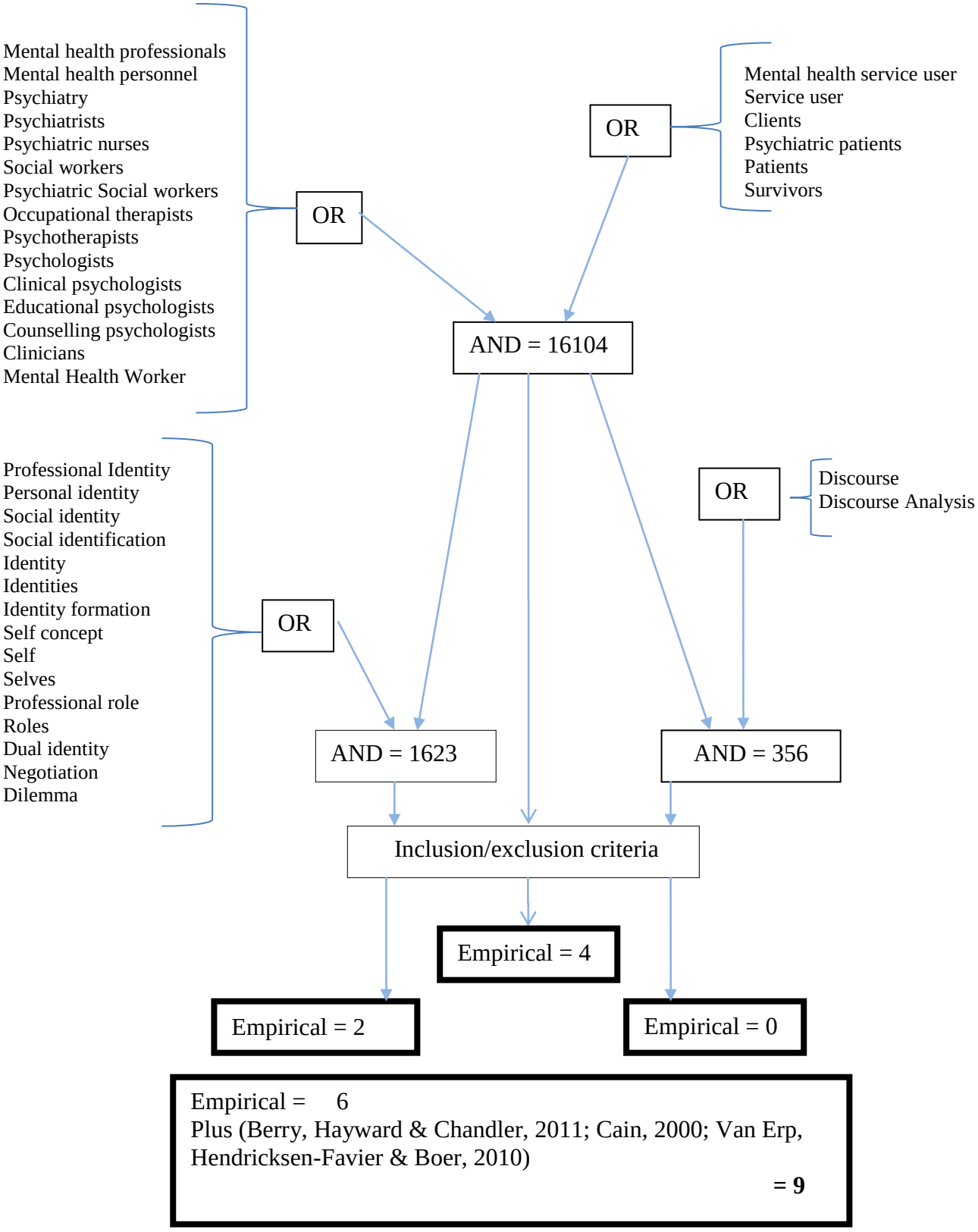
Appendix D

Literature Search Flow Diagram – 'Mental Health Service Users' Employed in Mental Health Services



Appendix E

Literature Search Flow Diagram – Overall Search - 'Mental Health Professionals' who are/have been 'Mental Health Service Users'



Appendix F

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Appendix G

Letter of favourable opinion gained from Stanmore Research and Ethics Committee

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Appendix H

Letter Confirming R&D Approval

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Appendix I

Progress Report

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Appendix J

Ending Reports to REC, R&D and Participants

Project Title: How do ‘mental health professionals’ who are also, have been ‘mental health service users’ construct their identities: A discourse analysis.

Executive Summary: Literature suggests that there are a growing number of ‘mental health professionals’ speaking out about their own experiences of using mental health services verbally or through professional journals and autobiographies. Recent policy, embraced by mental health services, has called for a culture where lived experience of mental health problems is viewed positively in ‘mental health professionals’ who have it (Shepherd, Boardman & Burns, 2009; 2010).

Research suggests that these professionals face dilemmas when constructing their identity because they are drawing on two identities that are viewed as fundamentally different (ResearchNet, 2010). From a traditional medical/psychiatric model, ‘Mental health professionals’ are viewed as ‘experts’, powerful, trustworthy, autonomous and are listened to (Davis, 2003; Slade, 2009), whereas ‘mental health service users’ are viewed as powerless victims and passive recipients, developing a dominant identity of a ‘mentally ill’ patient (Bassman, 1997; Frese & Davis, 1997; Slade, 2009). However there is limited research that explores how these professionals construct their identity.

The current project aimed to address this gap by exploring how ‘mental health professionals’ who are/have been ‘mental health service users’ construct their identity using a social constructionist epistemology; discourse analysis, which views identity as fluid and continuously renegotiated in social contexts (Davies & Harré, 1990; Potter & Wetherell, 1987). Ten participants who self-identified as ‘mental health professionals’ who are/have been ‘mental health service users’ volunteered to take part and were interviewed.

Participants constructed their identities in many different ways. They constructed their identity as separate identities, drawing on two main identity constructions; 'professional identity' and 'patient/mental health service user identity'. What occurred throughout the text, was that participants drew on, presented or had these separate identity constructions imposed upon them, in a way that made them switch/flip-flop between them, therefore developing an 'un-integrated identity' construction. Participants also developed some sense of an 'integrated identity', where they were able to draw on all their experiences, which where were viewed as equally important and complementary.

Participants drew on a wide range of discursive resources to construct their identities, and appeared to present their different identities to differing degrees depending on the professional context within which they found themselves. Within the 'professional identity' construction participants drew on professional, psychological, medical/psychiatric and academic/achieving discourses. These discourses positioned 'mental health professionals' as knowledgeable, valued, useful, competent, responsible and therefore powerful. They were viewed as 'experts' and listened to by others, leaving themselves to feel wanted and special.

Within the 'patient/mental health service user identity' construction participants drew on a patient/mental health service user discourse, linked to medical/psychiatric and medical power discourses. These discourses positioned 'mental health service users' as powerless, weak, fragile, devalued, disempowered, judged, subservient, incapable and untrustworthy. However within the 'patient/mental health service user identity' construction participants also drew on a personal recovery discourse, which appeared to construct a more positive identity. Participants also drew on an anti-medical/psychiatry discourse and developed a 'survivor identity' construction.

Within the 'un-integrated identity' construction participants drew on the above two identity constructions and the discursive resources available within these. Participants spoke

about finding it hard to be a ‘mental health professional’ who is also a ‘mental health service user’ and spoke about the ‘them and us’ divide within society between ‘mental health professionals’ and ‘mental health service users’, which made them feel as though they could not be both and had to hide part of their identity. By drawing on both the ‘professional identity’ and ‘patient/mental health service user identity’ constructions, participants were drawing on conflicting discourses with different power implications.

Within the ‘integrated identity’ construction participants drew on wounded healer, lived experience, use of self, activist and normalising discourses. Drawing on these discourses enabled participants to use their personal experiences and their professional knowledge. This allowed for new/specialist knowledge, skills and perspectives to develop and be valued. It afforded participants a space to speak and get their needs met, when they previously may have been silenced or not found a way to draw on all these experiences, potentially reducing ‘them and us’ barriers, power dynamics and mental health stigma.

Appendix K

Ethics Approved Consent Forms

Trust and University LOGO

Project Title: Negotiating Identity as a Mental Health Professional and a Mental Health Service User: A discourse Analysis

Name of Researcher: _____

PLEASE INITIAL THE BOXES

1) I confirm that I have read and understand the information sheet dated _____ (version _____) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactory. ☐

2) I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3) I agree to having my interview audio recorded. ☐

4) I agree that anonymous quotes from my interview may be used in published reports of the study findings. ☐

5) I agree to take part in the above project ☐

Thank you for offering to take part in this study

Name of Participant _____ Date _____

Signature _____

Name of Person taking consent _____ Date _____

Signature _____

Researchers and Supervisors contact information

Appendix L

Ethics Approved Semi-structured Interview Schedule

Negotiating Identity as both a Mental Health Professional and Mental Health Service User: A Discourse Analysis

Semi-Structured Interview Schedule

Thank you for agreeing to take part in the study. I hope that you find it interesting.
The interview will last about an hour, and will be recorded.
First we are going to go through the information sheet and consent form. I will ask you to sign the consent form if you are happy to go ahead and participate in the research study.

You can stop taking part at any time, and you don't have to give me a reason for this.
If you stop, anything you have said will not be used in the study and will be deleted at your request.
You can ask me to stop recording at any time and take a break.
Do you have any questions before we begin?
Ok, so if you are ready I will begin recording.

I am going to begin by asking you some questions about your life story

- I would like to ask you to tell me a little about your story? Can you tell me about your path in life to where you are today?
- Could you tell me a little more about your current professional role?
    - What was your path to being in this current role? OR How did you come into this role?
    - What would you say are the key landmarks in your career?
- Can I ask what drew you to take part in this study?

I would know like to ask you some questions about your identity

- What does it mean to you to be *'a professional' [Use their own words].*
    - Can you say more about that?
- What does it meant to you to be *a 'service user' [Use their own w*ords].
    - Can you say more about that?
- You mentioned being *'a service user' [use their own words],* could you say something about your choice of words there?
    - You could have used a different term or phrase and what would that have meant?
    - Can you say more about that?
- Can I ask what it means to you being both *'a professional' [use their own words] and a 'service user' [use their own words]?*
    - Can you say more about that?
- You mentioned your *'dual role/identity' [use their own words],* would you like to say something about your choice of words there?
    - You could have used a different term or phrase and what would that have meant?
    - I used the term 'dual identity/role' when describing the project, is this a useful description or not?
    - What do you think about phrases like this?

    - Are they useful or less useful at other times?
    - Can you say more about that?
- Can you think of a recent example where your identity was important, with what you did or didn't do, said or didn't say?

I would know like to ask you some questions about how your identity plays out in different professionals' contexts

- How do you draw on the different parts of yourself we have just spoken about in different professional contexts?
    - Can you tell me a bit more about that?
    - What about in meetings, when with colleagues or clients?
- Have you spoken about your 'dual role/identity' [use their own words] with others at work?
    - What parts of yourself does it seem possible to talk about openly at work? Why?
    - Can you tell me more about this?
- Have you chosen not to talk about your 'dual role/identity' [use their own words] with others at work?
    - What parts of yourself does it not seem possible to talk about openly at work? Why?
    - Can you tell me more about this?

Now I want to move on to think about how others talk about your 'dual identity/role' [use their own words] at work

- Do you know how others talk about your *'dual role/identity' [use their own words*]?
    - Can you tell me a bit more about that?
- How do you feel others respond to your '*dual role/identity' [use their own words]*?
    - Can you tell me a bit more about that?

Now I would like to ask a few questions about what you think the outcome of having this '*dual role/identity' [use their own words*] are?

- What do you think are the benefits of having this '*dual role/identity' [use their own* words]?
- What do you think are the limitations of having this '*dual role/identity' [use their own* words]?
    - Can you tell me a bit more about that?
- Do you ever choose to use your '*dual identity/role' [use their own words*]?
    - Can you tell me a bit more about that?
- Do you think there are any consequences, either positive or negative, in understanding your 'dual role/identity [use their own words], in the way you have described it to me today?
    - Can you tell me a bit more about that?

I wanted to end with a few question about how you found this interview today

- What has it been like talking about this with me?
- Have you felt aware of wanting to say certain things to me as a trainee, or in relation to my reporting this research to a wider audience?
- Anything else you would like to say?

During the interview I asked you questions about your life including personal information, did this raise any concerns for you or cause you any distress? [follow participant distress guidelines].

Is there anything you have said that you don't want used in the study? If so I will remove it from the recording.

Other people I have interviewed have asked me for a copy of the questions as they felt they would have after thoughts that they may want to put in an email. Would you like a copy?

Would it be ok for me to contact you if I need further information at a later date?

Do you have any questions?

Thank you for talking with me.

[Stop Recording]

Appendix M

Ethics Approved Advertisement

Trust and University LOGO

Are you a mental health professional?

Are you or have you been a mental health service user?

Have you worked within your professional role whilst having this dual identity, within the past 18 months?

Are you interested in taking part in a research project?

If you answered yes to all these questions then you may be interested in taking part in my project.

I am looking at what it is like for people who are both mental health professionals and mental health service users in their professional work place.

I am interested in how you see yourself and the challenges and opportunities you encounter.

Taking part in this project would involve between 60 and 90 minutes of your time and would be very much appreciated.

Researchers contact information

Appendix N

Ethics Approved Participant Information Sheet

Trust and University LOGO

Participant Information Sheet

Study Title: Negotiating Identity as a Mental Health Professional and a Mental Health Service User: A discourse Analysis

Hello.
My name is _____ and I am a Trainee Clinical Psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you have some more information in order for you to understand why the research is being done and what it would involve for you to take part.

What is the purpose of the study?
This study is part of my doctorate in Clinical Psychology at Canterbury Christ Church University and will help towards my qualification.
It is possible that participating in this study could provide you with the opportunity to explore how you talk about and understand your identity as both a mental health professional and mental health service user. It may also provide you with the opportunity to voice and for others to hear new 'talk' from people in this position, and therefore could potentially reduce the stigma associated with mental illness and dispel prejudice.

Why have I been invited?
You have been invited to take part in this study as you have identified yourself as someone who is a mental health professional and as someone who has previously or is using mental health services. You have also identified yourself as someone who has worked in their professional role after or whilst being a service user.
You and others interested in the study would have approached me after seeing advertisements and invitations for the project in National Health Service Trusts, service user groups, professional magazine, clinical training cohorts or through websites.

Do I have to take part?
It is up to you to decide to join the study. If you agree to take part, I will ask you to sign a consent form. However, you are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?
If you decide to take part in the study I would like to meet with you for approximately one to one and a half hours. This will be your only involvement in the study even though the whole project will last just over a year.
During this hour or so I would like to interview you about your experience of being both a mental health professional and a mental health service user. I am interested in the ways you have found to talk about, and how you understand being both a professional and service user

and how this plays out in different professional contexts. I will therefore ask you many questions surrounding these topics.
I will need to audio record the interview to enable interviews to be reviewed at a later date. I will ask you to provide signed consent to audio record the interview and use anonymous quotations in the write up of the study.
I will analyse the interviews using a qualitative methodology; Discourse Analysis. Discourse analysis looks at the way people speak, how this speech creates a view of themselves in relation to others, and how this positions them within different social contexts, particularly in relation to who has social power.

Expenses
Travel expenses are available. A maximum of £10 per participant can be refunded. If you live outside South East England, it may be possible to conduct your interview by phone or Skype.

What are the possible benefits of taking part?
It is possible that participating in the study could provide you with the opportunity to explore how you talk about and understand your identity when being both a mental health professional and service user. It may also provide you with the opportunity to voice and for others to hear new ways of 'talking about these identities'; potentially reducing the stigma associated with mental illness and dispelling prejudice.

What are the possible disadvantages and risks of taking part?
Throughout the interview I will ask you questions about your life and we will be exploring personal information. Please be aware that you do not have to answer all my questions and only need to share information you are comfortable sharing. Please ask for breaks when needed. It is important for participants to be aware that the interviews may cover sensitive issues that may be upsetting and that I recommend they you have an agreed person to talk to should this become an issues for you, before you take part in the study. At the end of the interview there will be some time to explore what it felt like answering the questions and to consider any concerns it may have raised for you.

What if there is a problem?
Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed.
If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to answer your questions (_____).
If you remain unhappy and wish to complain formally, you can do this by contacting the lead supervisor of this project.

Will my taking part in the study be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence.
All information which is collected from you during the course of the research will be kept strictly confidential, and any information you provide which leaves NHS, University or personal premises will have your names and address removed so that you cannot be recognised. I will be the only person who has access to identifiable data. The anonymised data will be retained for a period of 10 years by Canterbury Christ Church University and will be disposed of securely after this period.

What will happen if I don't want to carry on with the study?
If you begin the study but decide that you no longer want to take part in the study you can withdraw at any time by notifying me that you wish to withdraw from the study. I will then extract and destroy, part or all of the data you have provided at your request.

What will happen to the results of the research study?
The results of the research will be written up and submitted as part of my doctoral thesis. A summary of the study, including results will also be sent to the relevant NHS Trust's Research and Development Department. A paper will be submitted for publication in professional forums.
All names will be changed for the purpose of writing up the study, so participants will not be identified in any report/publication. Anonymised quotes from the interview will be used in reports.

Who is organising and funding the research?
The study is organised and funded by Canterbury Christ Church University.

Who has reviewed the study?
All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by NRES London-Stanmore Research Ethics Committee.

Further information and contact details
If you would like to speak to me and find out more about the study of have questions about it answered, you can leave a message for me on a 24-hour voicemail phone line at _____. Please say that the message is for me _____ and leave a contact number so that I can get back to you.

Many Thanks

Researchers contact information

Appendix O

Written Personal Accounts Analysis

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Appendix P

Respondent Validation

EMAIL

SUBJECT - Research Project: Mental Health professional who are/have been mental health service users - Reviewing themes/codes.

Dear _____,

You may remember that I contacted you at the beginning of the year asking whether you would be happy to review the codes/themes of my analysis for my research study looking at how mental health professional who are/have been mental health service users construct/negotiate their identity.

I was planning to contact you and send my analysis out in March, however there was a delay in the project, so sorry for the delay in getting back to you.

If you are still interested in talking part, that would be very much appreciated. I have attached my participant information sheet, just to remind you of my project and I have also attached a summary of my analysis.

If you would like to share your comments on these summary findings I also need you to answer these three short questions.

- What is your professional role?
- Have you worked in this professional role in the last 18 months?
- What is your mental health service user experience?

It would be great to hear what you think of the results and whether there are similarities/differences to your experiences of being in this 'dual role'.

If you could reply ASAP and by the end of June that would be very much appreciated. If you have any questions please feel free to contact me.

Yours Sincerely

_____

Trainee Clinical Psychologist

Respondent Validation Summary of Findings

The participants, 'Mental health professionals' who are/have been 'mental health service users', constructed their identities in many different ways in their professional contexts. Participants constructed their identity as separate identities, with two main identity

constructions, that of a 'professional identity' and that of a 'service user/patient identity'. They drew on these separate identity constructions in different professional contexts.

Participants also constructed their identity in an 'un-intergrated way' and within this, drew on these two main separate identities, that of a 'professional identity' and that of a 'service user/patient identity'. What occurred throughout the text, within this 'un-intergrated identity' construction, was that participants drew on, presented or had these separate identities imposed upon them in a way that made the switch or flip-flop between them, therefore developing the sense that they had an 'un-intergrated identity'.

Participants also developed some sense of an 'intergrated identity', where they were able to draw on all their experiences in a way where they were viewed as equally important. Participants drew on some on the previous discursive resources, as well as additional discursive resources.

They drew on a wide range of discursive resources to construct their identities, and appeared to draw on these different resources and present their different identities to differing degrees depending on the professional context within which they were in.

	Identity Construction	**Discourses drawn upon**
Separate Identities	'Professional Identity'	Professional discourse Medical discourse Psychological discourse Discourse of medical power Academic/Achieving discourse Discourse of expected and disallowed ways of being' within the 'professional identity'.
	'Service user/patient Identity' ('Survivor' identity)	Service user/patient discourse Medical discourse Personal recovery discourse Anti-psychiatry/medical/therapy/system/organisational/ professional discourse Discourse of needing labels
Un-intergrated	'Un-integrated Identity' Made up of 'professional identity' and 'service user/patient identity'. ('Infiltrator identity')	*Discourse associated with 'professional identity'* construction. *Discourse associated with this 'service* user/patient id*entity' construction.* Service user movement discourse Discourse of use of self = not allowed
Integrated	'Integrated Identity'	Wounded healer discourse Lived experience discourse Normalising discourse Activist Discourse Discourse of use of self = allowed Coming out discourse

Appendix Q

Coded Transcript

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Appendix R

Reflexive Research Diary

January 2011 – Attended the university research fair. I was really drawn to the projects focusing on recovery and service user involvement. I wonder whether I could meet with SH to discuss project ideas and meet with NS to talk about possible recruitment opportunities.
February–March 2011 – At the research fair SH presented a recovery project looking at people's positive experiences of recovery. I was particularly interested in the mental health professionals themselves who had used mental health services. This reminded me of a lecture we had at the beginning of training where three course lectures spoke about their own mental health experiences, which had really stuck in my mind, however I have not heard anything like this since or any conversations about professionals with mental health problems, why is this? I also felt that a recovery project would work well as I have been involved in service user involvement projects within trusts, am a member of the service user advisory groups at Salomons and have been interested in hearing different people's opinions of service user involvement.

March 2011 – Meeting with SH to discuss project ideas. A good meeting, I could work with SH and her research knowledge would be really beneficial. We came up with an interesting idea, looking at how mental health professionals who have used mental health services develop their identity in their professional role. This was interesting because it appears that society separates these two groups and it would be beneficial to explore how they can come together. We wondered whether discourse analysis would be a useful methodology.
April 2011 – SH agreed to be my internal supervisor, great news! I met with NS to discuss recruitment. He was really positive about the project and felt that it was 'cutting edge', exciting; he also felt that he may know of some people who would meet my inclusion criteria, great news!

April–July 2011 – Started work on my proposal and began reading relevant literature, including the theory and methodology of discourse analysis. This is all brand new to me and I feel that I need to gain a better understanding of it before I can take the project any further. It's interesting reading and I really like the way it questions the taken for granted assumptions within society, but it is also very complicated, the language is complicated, there is a lot to read and I worry that I have bitten off more that I can chew. I tried to get focused by developing my research questions. At this stage of the project I am drawing on the critical realistic position and the idea of positioning theory by Harré and Langenhove (1999). I like these ideas and can relate to them, having felt pushed to do or say certain things during my mum's illness which were not necessarily representations of the trust. I feel that discourse analysis is the right methodology for my study, especially as mental health professionals and mental health service users are viewed as different in society; drawing on different discourses, have different identity constructions and roles. I spend a lot of time thinking and developing my semi-structured interview schedule, I think this is really important part of my project.

August 2011 – I was diagnosed with dyslexia. I have been thinking about how this relates to my project in the sense of a hidden disability and the dilemmas I have experienced in relations to disclosure and questions regarding my competence. I have also been reflecting a lot on the impact on my mum's illness, through reflective group and personal and

professional development on the course. It made me question how I carried on working when all that was going on, and that sense of wanting to be seen as coping as a professional.

September 2011 – Supervisors review my MRP Proposal. They provide really useful feedback but I think I am on the right lines which is great.

November 2011 – Salomons panel reviewed my proposal, I was apprehensive. There was a bit of a mixed view in the panel, with some really liking it, whereas I'm not sure that some got it, this made me worry about my viva. The panel approved my project which I was relieved about but also a little confused because of the mixed response in the meeting. They suggested immersing in discourse analysis theory/research and to start writing in the style.

January 2012 – I need to get back to the research after a break. I began the ethics application. Such a long form but it has helped me to focus and clarify my question, theory, inclusion/exclusion criteria, sampling and methodology. I spent some time trying to make it readable to those who have not come across discourse analysis before, however because I am still trying to get my head around the social constructionist 'talk' myself this is a challenge. I want to continue to develop this. Started section A, developed a mind map of all the different areas that link to my project (the changing NHS, medical/recovery models, stigma, identity, service users, wounded healers, distress/impairment, experts by experience) and began systematically reviewing the literature.

February 2012 – Had supervision to discuss my ethics form. Useful discussion about being aware of my own assumptions about the impact the medical/recovery model on service users and professionals identity constructions; are they always polarised, do they always develop clear identities, what influences them? We discussed the impact of where I recruited participants from bearing in mind the impact participants own and the services openness to these issues may have on the interviews. If I widened my recruitment strategy would I be drawing on different discourse available in different contexts?

March 2012 – Ethics form now complete. The ethics nightmare begins! IRAS suggested that I may be appropriate for a proportionate review because I was researching professionals. I informed them that I was working with professional who were/had also been service users, which seemed completely novel to them, the lady responded, 'oh, you're doing something quite different then'. I then went forwards and backwards between the three ethics panels with each suggesting that it was for another research panel to review, this was very frustrating but I eventually got IRAS to accept it for a full review. This highlighted to me, that maybe people do not recognise the concept of mental health professionals with mental health problems or potentially people don't talk about it and wondered whether my research project not fitting also represented something of my participants' experiences, not fitting into the box that people expect you to fit into.

May 2012 – Ethics panel. A rather scary experience, with lots of people but the panel were nice. I was shocked that they did not ask me any questions about possible distress caused by my questions however they did in the follow-up letter. I wondered whether this linked to the idea that professionals are somehow beyond distress/detached from it.

June 2012 – I gain R&D approval. This was relatively easy compared to the ethics nightmare. I continued working on section A of the MRP, conducting systematic literature searches and developing literature flow diagrams. I am trying to link together all the literature I have

reviewed to develop my argument into a coherent narrative. I'm not sure how I am going to pull it all together in just 5500 words, there just seems too much to write about.

July 2012 – I begin recruitment. I feel good about recruitment, maybe NS positivity is rubbing off on me. NS and I met to discuss a recruitment strategy and decided to use a staggered approach. Stage one; recruit through service user advisory groups and the NHS trust and stage two; recruit through recovery networks and other sources. I hope I get enough participants but I agree with a staggered approach because I do not want to let people down.

July 2012 – I conducted a pilot interview, with a potential participant. This was really helpful and the participant gave me some good feedback about my schedule but felt that the basis of it was good, just some questions needed rewording and the order of questions changed. It was good to practice doing the interview, see how thought provoking the questions were and experience listening to someone's story. I found it a really interesting and useful learning experience. I also felt like I could use this interview for my analysis which felt good, one down nine to go, it felt great to get started!

August 2012 – Transcribed my pilot interview. Initially it appeared that there were two different identities, a service user identity and a professional identity. I think it's helpful to log these initial impressions because then when I come to analyse I can review these and also bear in mind my assumptions. Transcribing also left me with more questions that I wanted to as, maybe I felt like I couldn't ask them at the time, what was this about, what silenced me, the story, the participant, the conversation, our positions, power (trainee/researcher/professional)? Again I questioned whether my experienced of being silenced represented something about the participants experience. I conducted two more interviews – Interview number two was difficult at times because if felt like the professional position the participant was in was a really difficult place to occupy at times, as if he couldn't be himself or have his views, was forced to be something else, was stuck and often silenced by others. There was a very anti-psychiatry vibe to this story. Are there some identity constructions and discourses that I am tapping into here? In the third interview the participant held onto a strong sense that everyone could develop a mental health problem and being a mental health professional wasn't that much of a different thing. There was something quite normalising about the conversation.

September 2012 – I conducted my fourth interview. This was a very long interview, which was conducted on two occasions and I think this occurred because the participant was quite muddled about their experiences and identity, and reflected on this. Recruitment is going well and I am really enjoying the interviews. I am trying to keep on top of transcribing whenever I get a spare hour or so. I start to think about analysing and I hope the data that I am gathering is useful. I also wonder how I am going to represent the complexity of everyone stories because they are all so different and rich, and there also seems to be contradictions within each individuals 'talk. There is a sense that they are sometimes talking from different parts of themselves and other times combining and drawing on all their knowledge and experiences. Does this represent a range of identity constructions?

October 2012 – I conducted my fifth and sixth interview. The fifth participant described a spiritual journey which was sometimes hard to follow, however really interesting to be hearing a range of perspectives. The sixth participant really drew in their personal experiences of their own mental health problems when in their professional role, wounded healer? Disclosure is coming out as a big dilemma for all participants.

Trying to focus back to section A. Doing some more reading linked to the modern and post-modern theory of identity, but this area is huge, I feel like I need a sabbatical to read everything. I plan to meet with SH to discuss a way forward and we speak about how to structure section A.

November 2012 – I conducted my seventh interview. I felt as though recruitment had started to slow down a little so I met with both supervisors and we decided that it was time to go through to the second stage of recruitment. I sent email out to recovery network and was amazed by the positive response. I had so many professionals come forward that I got enough for all my interviews and then with discussions with supervisors decided to ask the others if they would conduct respondent validation.

December 2012 – Conducted interview eight, nine and ten. Yay I am all done! Really pleased about getting it all done before Christmas and going to try and transcribe these last three over the break. These last four interviews made me think lost about the similar dilemmas participants were experiencing. They also made me think about how participants appeared to construct their identities differently depending on the different contexts within which they were in, some were aware of this and some were less aware. There was also sometimes a sense that they did not have a choice but their identity was imposed upon them or expected of them.

January - February 2013 – Took time out of my MRP to focus on other pieces of work and have a holiday!

March 2013 – Time to get back to it. I met with other trainees conducting recovery based research. It was really interesting to hear other people projects, as well as, get a sense of where people were at and share some tips and ideas. I had supervision with SH to think about analysing my data. We reviewed the steps that I was going to follow (Willig, 2008) and SH agreed at which staged she would review a blank transcript and audit trail. The analysis part feels really daunting as there is so much paper to get through and I want to do my participants justice. I took some annual leave and spent 10 solid days analysing my first three transcripts, trying to really immerse myself in the data, reading and re-reading different part of the texts, asking and re-asking my research questions and following the steps of the analysis. I also reviewed my research diary and held my previous thoughts and assumptions in mind, but tried distance myself from these in order to really draw out what the text was saying. Discourse analysis turned out to a very time consuming methodology, which made my head hurt at times, but I actually really enjoying it, it felt like a useful methodology to interpret the data and I felt like I am getting it. I write my methodology and rational for section B and get good feedback from SH.

April 2013 – The MRP feels very demanding at the moment I feel like I am switching between section A and analysing and not having enough time to give all my full attention to either. I have written far too many words for my section A but decided to send it to my supervisors to get some feedback. I got some really useful feedback from SH which gave me direction and some positive feedback from NS, which acknowledged my hard work which gave me a boost to get it done. I have to cut lots out which seems like a waste of some good work, but my manger suggests that maybe I can use this to write a book one day! I have now analysed three more interviews, I am getting quicker but also taking my time not to rush and overlook things.

May 2013 – Met with SH to discuss my analysis and hear her reading of a transcript. This was really useful and there was a lot of overlap in our interpretations. I analysed the last four interviews. I spent a lot of time drawing the individual interview analyses together and drafted a results write up. I have so much to say because the data is so rich and so many amazing quotes that I want to include but I am trying to keep within the word count, but I worry about it making sense to the reader, highlighting the complexity and variability and doing justice to participants. I feel completely absorbed by my MRP at the moment that it is hard to attend to anything else including placement and life in general. I seek support from my fiancé and family, who remind me that it only a few more months and then I can readdress the balance. Luckily I am still finding it interesting and have really enjoyed the analysis process and feel as though I have done this as thoroughly as I can.

June 2013 – I received some results from work handed in earlier this year. It was good news which I was really pleased about because bad news would have made me wobble which would be difficult at this stage. These results gave me the confidence and motivation to continue with the MRP, there feels like there is still a lot do to but I push through. I begin sending full drafts of section A and B to my supervisors and start work on section C, D and references.

July 2013 – The final stretch, I'm so pleased that this is going to come to an end as I am so tired. It's hard work finalising things and things seem to always take longer than predicted by maybe that because I'm so tired. I'm looking forward to rest and am so pleased that I have saved some annual leave and have a week off to look forward to.

Appendix S

Journal of Mental Health Submission Guidelines

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